STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility allowed residents to sit and wait to be fed in the assisted dining room while other residents were being fed for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed during a lunch meal. Findings included: 1. Resident #26 was admitted to the facility on 8/16/10 with multiple diagnoses including Dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/24/16 indicated that Resident #26 had memory and decision making problems and needed extensive assistance with eating. The care plan for Resident #26 was reviewed. The care plan for nutrition dated 6/14/16 included approaches to assist the resident with meal intake routinely and for the resident to eat in the assisted feeding room. On 8/24/16 at 12:20 PM, Resident #26 was observed in the assisted dining room with her lunch tray in front of her. There was no staff member feeding her at this time. There was a resident on the same table who was being fed by a family member. On 8/24/16 at 12:25 PM, there were 12 residents	F 241	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under state and federal law and to demonstrate the good faith attempt by the provider to improve the quality of life of our residents. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #26 is receiving assistance with meals in a timely manner. Resident #94 no longer in the facility. Resident #81 no longer in the facility. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	9/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2016

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F 241	Continued From page 1 observed in the assisted dining room with 3 nurse's aides (NA). One of the twelve residents was able to feed self and one resident was being fed by a family member. One nurse aide was observed feeding one resident at a time while other residents were waiting to be fed. At 12:40 PM, 3 additional staff members came to the assisted dining room to help feed the residents. On 8/24/16 at 12:45 PM, NA #2 was interviewed. NA #2 stated that 3 NAs were scheduled to the assisted dining room every meal. There were eleven residents in the assisted dining room that needed to be fed. The residents had to wait to get fed. On 8/24/16 at 1:00 PM, NA#2 was observed to feed Resident #26. On 8/25/16 at 2:25 PM, the Administrator was interviewed. The Administrator indicated that the NAs in the assisted dining room should be feeding 2 residents at a time but they were not. She also stated that she expected the residents to be fed in a timely manner. 2. Resident #94 was admitted to the facility on 4/23/15 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 6/8/16 indicated that Resident #94 had memory and decision making problems and needed extensive assistance with eating. The care plan for Resident #94 dated 6/8/16 indicated to assist the resident with eating.	F 241	All residents have the potential to be affected. 100% audit of all active residents completed on 09/15/2016 by Dietary Manager to determine the assistance required during meals and dining room designation for all three meals. Findings documented on "Dining Designation Audit" tool. Measures put into place or systemic changes made to ensure that the deficient practice will not re-occur: Moving forward, three tables in the main dining room will be designated effective 9/19/2016 for residents who requires assistance with feeding. Nursing assistance will be feeding two residents at a time, effective 9/12/2016. Trays will be delivered to one table at a time effective 9/19/2016. The Director of Nursing, Assistant Director of Nursing, nursing supervisor and/or Corporate Quality Assurance & Performance Improvement Director completed 100% education of all current nursing staff, to include full time, part time and as needed employees. This education will be completed by 9/22/2016. This education will cover facility new dining processes to include; assisting residents on one table at a time, feeding two residents on the same table at one time and ensure all residents are fed in a	

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F 241	Continued From page 2 On 8/24/16 at 12:20 PM, Resident #94 was observed in the assisted dining room with his lunch tray in front of him. There was no staff member feeding him at this time. Other residents in the dining room were being fed by staff members. On 8/24/16 at 12:25 PM, there were 12 residents in the assisted dining room with 3 nurse's aides (NA). One of the twelve residents was able to feed self and one resident was being fed by a family member. One nurse aide was observed feeding one resident at a time while other residents were waiting to be fed. At 12:40 PM, 3 additional staff members came to the assisted dining room to help feed the residents. On 8/24/16 at 12:45 PM, NA #2 was interviewed. NA #2 stated that 3 NAs were scheduled to the assisted dining room every meal. There were eleven residents in the assisted dining room that needed to be fed. The residents had to wait to get fed. On 8/24/16 at 1:02 PM, Nurse Aide #3 was observed to feed Resident #94. On 8/25/16 at 2:25 PM, the Administrator was interviewed. The Administrator indicated that the NAs in the assisted dining room should be feeding 2 residents at a time but they were not. She also stated that she expected the residents to be fed in a timely manner. 3. Resident #81 was admitted to the facility on 6/11/16 with multiple diagnoses including Hypertension. The annual Minimum Data Set (MDS) assessment dated 6/17/16 indicated that Resident # 81 had memory and decision making	F 241	timely manner. Any nursing staff not educated by 9/22/2016 will not be allowed to work until educated. This education will taught annually and added to the new hire orientation packet. Monitoring Process The Director of Nursing, Assistant Director of Nursing, Nurse supervisor, Director of Social Services, Dietary manager, and/or Facility Administrator will monitor dining rooms for one meal daily x 4 weeks, then one meal weekly x 4 weeks and then one meal monthly until substantial compliance is maintained for three consecutive months. This monitoring is to ensure residents are fed timely, one table is served at a time and qualified employees will feed two residents at one time. Any negative findings identified during the monitoring process will be corrected promptly. This monitoring will be documented on dining room monitoring tool. The Director of Nursing will report findings of the dining room monitoring process to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved for three consecutive months.	

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F 241	Continued From page 3	F 241		

problems and needed extensive assistance with eating.

The care plan for Resident #81 dated 6/11/16 indicated to assist the resident with eating.

On 8/24/16 at 12:20 PM, Resident #81 was observed in the assisted dining room with his lunch tray in front of him. There was no staff member feeding him at this time. Other residents in the dining room were being fed by staff members.

On 8/24/16 at 12:25 PM, there were 12 residents in the assisted dining room with 3 nurse's aides (NA). One of the twelve residents was able to feed self and one resident was being fed by a family member. One nurse aide was observed feeding one resident at a time while other residents were waiting to be fed. At 12:40 PM, 3 additional staff members came to the assisted dining room to help feed the residents.

On 8/24/16 at 12:45 PM, NA #2 was interviewed. NA # 2 stated that 3 NAs were scheduled to the assisted dining room every meal. There were eleven residents in the assisted dining room that needed to be fed. The residents had to wait to get fed.

On 8/24/16 at 1:02 PM, NA #4 was observed to feed Resident #81.

On 8/25/16 at 2:25 PM, the Administrator was interviewed. The Administrator indicated that the NAs in the assisted dining room should be feeding 2 residents at a time but they were not. She also stated that she expected the residents to be fed in a timely manner.

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and record review the facility failed to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22). The findings included: Resident #22 was admitted 8/14/14 with cumulative diagnoses including diabetes, neuropathy, osteoarthritis, glaucoma and a history of falls. The most recent Minimum Data Set (MDS) assessment an annual assessment indicated the resident was moderately cognitively impaired and could walk with limited assistance of 1 person. The MDS also revealed that resident #22 walked in the corridor only once or twice during the 7 day look back period for the MDS, had no refusals of care and was unsteady when walking but could stabilize with human assistance. Review of the Restorative Nursing Referral from Physical Therapy dated 3/25/16 revealed the following instruction for Bed Mobility or Walking: " pt (patient) to ambulate 40-50 (feet) x 2 with seated rest break. Pt requires min A (minimum	F 242	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F242 Corrective actions will be accomplished for the resident found to have been affected by the deficient practice: Resident #22 receives ambulation assistance per preference by a restorative aide or assigned nursing assistant effective 09/19/2016.	9/22/16

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F 242	Continued From page 5 assist) (with) wc (wheelchair) follow and use of RW (rolling walker). Pt should have back brace and (illegible). " Review of the Restorative Roster for Resident #22 from 6/1/16 through 8/25/16 revealed Resident #22 had walked 50 feet over a duration of 15 minutes on a total of 8 days in June, 7 days in July and 1 day in August (16 days total). Resident #22 also received other restorative services such as range of motion, splint or brace application and transfer assistance on the 16 days he walked with restorative staff during this 86 day period as well as on 15 additional days during this period (6/1/16 - 8/25/16). On 8/25/16 at 1:52 PM Nursing Assistant #5 (NA # 5) was interviewed and stated that the Restorative Nursing Aids (RA) provided walking assistance to the residents who needed to have assistance with walking. She stated that the NA ' s on the floor did not do it. She also indicated that if the Restorative Aids were not available then residents who were assisted with walking by the Restorative Aids would not receive assistance with walking on those days. On 8/25/16 at 2:03 PM RA #1 was interviewed. She indicated that there were two RA ' s that usually worked but if they got pulled from Restorative care to work on the hall as Nursing Assistants then residents did not receive the restorative care indicated on their Restorative Referral such as walking. She added that there were a total of approximately 30 residents on the Restorative caseload and that she and the other Restorative Aide split the caseload with approximately 15 residents each. RA #1 stated that it was up to the RA to determine which of	F 242	Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 100% choices and preferences audit completed by the Director of Social Services on 09/15/2016 & 09/16/2016 to determine each residents choices and preferences, specifically in relation to walking. Non-interview able resident's choices and preferences were done by interviewing power of attorney and or guardian. Findings of this audit are documented on "Resident Choices Audit tool". On 9/15/16, 9/16/16 and 9/19/16, a 100% audit for all residents who are currently on restorative nursing program re-screened by a Licensed Therapist to ensure that each resident receives appropriate modalities with frequency and duration as determined by the screening. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Moving forward all current nursing assistants will be responsible to honor resident's choices of walking when requested during their shift and as appropriate, effective 09/19/2016. Resident choices and preferences to include choices for walking will be assessed on admission/readmission, quarterly and with significant changes on "Choices and Preference tool" by Director	

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F 242	Continued From page 6 their residents to provide restorative care to on the days they were assigned to restorative as there was no set schedule for the residents. In addition she said that sometimes they could not get to everyone on the caseload, especially if one of them had been pulled to work on the hall. She further indicated that if they were both pulled restorative care was not offered to Resident #22 or other residents on the caseload those days and that the Nursing Assistants on the hall did not provide restorative care such as assistance with walking when the RA ' s were not available. On 8/25/15 at 2:30 PM interview with the Administrator revealed it was her expectation that residents received assistance to walk daily if they were physically able to walk with assistance and they wanted to walk with assistance on a daily basis. On 8/25/16 at 3:32 PM Resident #22 was interviewed. He stated that he did want to receive assistance to walk daily as he thought it would help him maintain his ability to walk. He added that on some days he was offered assistance to walk but that he was not offered walking assistance daily. He added that he had not refused walking assistance in the past.	F 242	of Social Services or Activities Director. Effective 9/22/16. Any choices and preferences identified by the tool will be implemented as indicated. 100% education of residents rights and to include choices and preferences education involving all staff will be completed by 9/22/16 by the Director of Nursing, Assistant Director of Nursing and/or Director of Social Services. Any staff not educated by 9/22/16 will not be allowed to work until completed. This is included in the new hire orientation packet and will be done annually. Monitoring Process: Effective on 9/22/16, Activity Director or Administrator will review the completion of “Choices and Preference tool” daily (M-F) for 4 weeks, then weekly for 4 weeks and then monthly until substantial compliance is maintained for three months. Effective on 9/22/16, ‘resident appointed ambassador’ will monitor daily (Monday through Friday) to ensure residents choices and preference are implemented per “Choices and Preference Tool”. A ‘resident appointed ambassador’ is a department manager who is assigned to a set of residents to monitor and follow up with that resident as a point of contact. They will document their rounds on the ‘Ambassador Round Tool.’ The Director of Social Services will report audit findings to the Quality Assurance	

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F 242	Continued From page 7	F 242	and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to resolve grievances that were brought in the resident council meetings promptly. Findings included: The facility's policy on filing grievances/complaints, undated, was reviewed. The policy indicated that a grievance and or complaints may be submitted in writing by the resident or the person filing the grievance or complaint on behalf of the resident. They may also be verbalized to any staff member, who will be responsible for documenting the grievance/concern on the appropriate form. Upon receipt of a written grievance and or complaint, the appropriate designee will investigate the allegations and submit a written report of such findings to the administrator within 72 hours of receiving the grievance and or complaint. The administrator and the interdisciplinary team will review the findings with the person investigating the complaint to determine what corrective action, if any, need to	F 244	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under state and federal law and to demonstrate the good faith attempt by the provider to improve the quality of life of our residents. F244 Corrective Action will be accomplished for the resident found to have been affected by the deficient practice: Grievances about staffing and call bell responses identified on resident's council	9/22/16

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F 244	Continued From page 8 be taken. The resident or person filing the grievance and or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator or his or her designee, within 5 working days of the filing of the grievance or complaint with the facility. The resident council minutes for the last 6 months (March-August) were reviewed. The minutes dated 4/19/16 indicated that the residents had discussed issues on getting help in a timely manner and nurse aides saying " I'll be right back " but would not return. The minutes dated 5/24/16 indicated that the residents stated that the concern of getting assistance in a timely manner was still an issue. The minutes dated 6/21/16 indicated that residents continued to express concern of staff answering call lights and said they will be right back and would not come back or turned off the call light and would not come back. The minutes dated 6/28/16 indicated that several residents had complained that NAs would answer the call lights and said they will be right back but would not return. The minutes dated 7/19/16 indicated that the issue of NAs coming in and turning off the light and said that they will be right back but not returning was still an issue. The minutes dated 8/16/16 indicated that residents stated that the concern with staff coming in and turning off the lights and saying that someone is coming was still an issue. On 8/25/16 at 10:10 AM, Resident #67, the president of the resident council, was interviewed. Resident #67 stated that the concerns with short staff, not answering the call lights timely, and staff turning off call light were repeatedly brought up in the meeting. Resident #67 indicated that evidently, these concerns had not been resolved.	F 244	minutes on 4/19/2016, 5/24/2016, 6/21/2016 and 6/28/2016 resolved, resident receiving assistance with ADL and call bell responses resolved. On 9/20/16, the concerns were resolved by following up with the resident council to ensure no further issues with these areas. Corrective Action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have potential to be affected. 100% audit for all resident's council minutes in the last 12 months completed on 09/20/2016 by the administrator to identify any other repeated grievance that may warrant any follow up. Any finding will be implemented promptly. Findings of the audit included 9 occurrences within the last year of call bell concerns, and 6 occurrences of staffing concerns. Measures put in place or systematic changes made to ensure that the deficient practice will not re-occur 100% education of all staff will be done by the Director of Social Services, Director of Nursing and Regional Clinical Director on the grievance process from resident council and the buildings process beginning with receiving concerns to following up with a resolution to the appropriate party. This education will be completed by 09/22/2016, any staff not	

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F 244	Continued From page 9 On 8/25/16 at 8:30 AM, the Activity Director (AD) was interviewed. The AD stated that she was responsible in setting up the resident council meeting. The AD indicated that when a resident had a concern that was brought up in the meeting, a grievance form was completed and given to the DON or Administrator. The AD acknowledged that the same issues with short staff, not answering the call light timely, turning off of call lights were repeatedly brought up in the meeting. 8/25/16 at 2:25 PM, the Administrator was interviewed. The Administrator stated that she was aware of the issues from the resident council and the staff had been in-serviced on answering of call lights timely. The administrator also stated that she was new to the facility as administrator and she had not done any audit or monitoring yet regarding answering of call lights timely or staff turning off call light.	F 244	educated by 09/22/2016 will not be allowed to work until educated. The Director of Nursing, Assistant Director of Nursing and Regional Clinical Director will conduct an education for all staff, all departments, to include full time, part time and as needed staff, in relation to call bell response. Education to include staff responsibilities for answering call lights timely and to not turn off call light until residents needs are met. This education will be completed by 09/22/2016, any staff not educated by 09/22/2016 will not be allowed to work until educated. Effectively 09/22/2016; The administrator will review resident council grievances within seventy-two hours of the report. The resident council president will receive follow-up from the investigation as well as corrective action recommended within five working days of grievances filed. Monitoring Process: The Administrator, Department Managers, Nursing Supervisor, and/or Manager on Duty will monitor all grievances in relation to call bell responses, staffing or turning off call bell before care is rendered daily (Monday through Friday) for four weeks, weekly for four weeks, then monthly for three months afterwards or until the pattern of compliance is maintained. The Administrator or Director of Social	

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F 244	Continued From page 10	F 244	Services will follow-up with resident council president weekly x4 weeks, then monthly x3 months to ensure grievances have been resolved.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/22/16

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F 272	Continued From page 11	F 272		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews, the facility failed to comprehensively assess three of twenty-six residents for completing the Care Area Assessment (CAA), not completing the height and not doing the resident interview for customary and routine activities on three comprehensive assessments for Resident #166, #88 and #96. The findings included:

1. Resident #166 was admitted to the facility 3/31/16 and readmitted on 5/28/16 (hospitalized from 5/26--5/28/16). Cumulative diagnoses included, in part, unilateral femoral hernia without obstruction hypertension, atrial fibrillation, dysphagia (difficulty swallowing), aphasia (impairment of speech), thyroid disorder, gout and dementia without behavioral disturbance.

An Admission Minimum Data Set (MDS) dated 4/7/16 indicated resident was rarely/ never understood. Staff interview indicated resident had short term and long term memory impairment. Resident #166 required extensive assistance for toileting. Resident #166 was occasionally incontinent of bladder and freq. incontinent of bowel.

A review of the Care Area Assessment (CAA) for urinary status revealed the CAA was blank.

This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

Corrective Action will be accomplished for the resident found to have been affected by the deficient practice:

Resident #166 Care Area Assessment for urinary incontinence for MDS assessment dated 4/7/2016 was completed by MDS Nurse #1 on 9/15/16 .
Resident #96 is no longer in the facility. No further action needed for this resident.
Resident #88 is no longer in the facility. No further action needed for this resident.

Corrective Action will be accomplished for those residents having potential to be

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F 272	Continued From page 12 On 8/25/2016 at 10:46 AM, an interview was conducted with the MDS Coordinator who stated she was not sure why but the CAA's were not there. She stated there was a time when she would go back in to check the CAA's and the CAA's would be blank. She stated she believed that occurred in March. She stated IT (computer technology staff) was notified about the blank areas and they stated there was not a problem with the program. She stated she now checks to make sure the CAA's are completed. On 08/25/2016 at 3:18 PM, an interview was conducted with the Administrator who stated she expected the MDS to be accurate and complete per the clinical record. 2. Resident #96 was admitted on 4/4/16 with multiple diagnoses that included multiple sclerosis. A nursing note dated 4/11/16 indicated Resident #96 was alert and oriented and was able to make her needs known to staff. A social service note dated 4/11/16 indicated Resident #96 was alert and verbal, she was able to make her needs known, and she was able to make daily decisions. The Admission Minimum Data Set (MDS) assessment for Resident #96 dated 4/11/16 indicated she had moderate cognitive impairment, adequate hearing, clear speech, was usually understood and understood others. Section F, the Preferences for Customary and Routine Activities Section, indicated the resident interview for daily and activity preferences was not conducted because Resident #96 was rarely/never understood. There were no answers	F 272	affected by the same deficient practice: All residents have the potential to be affected. 100% audit of most recent comprehensive MDS assessment to ensure Care Area Assessments were completed when triggered was done by MDS Nurse #1 and #2 on 9/15/16, 9/16/16, and 9/19/16. The results of the audit indicated 4 other comprehensive assessments with missing care area assessments. Assessments were modified to indicate appropriate completion of the care area assessment. 100% audit of most recent comprehensive MDS assessment Section F to ensure interview for customary routine and activities was conducted per RAI Guidelines by MDS Nurse #1 and #2 on 9/15/16, 9/16/16, 9/19/16. This audit included reviewing question B700 to ensure interview to ensure customary routine and activities was done if indicated for section F. The results of the audit indicated 4 other Section F's were not documented appropriately. 100% audit of most recent resident assessment to ensure height is coded in question K0200A was done by Certified Dietary Manager on 9/15/16. Any findings will be addressed per RAI guidelines as indicated.	

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F 272	Continued From page 13 indicated for the remainder of the resident interview for daily and activity preferences (questions F0400 through F0500). The staff assessment of daily and activity preferences was completed for Resident #96. An interview was conducted with the Administrator on 8/25/16 at 2:53 PM. She indicated her expectation was for the MDS to be fully completed based on the resident's medical record. An interview was conducted with the MDS Coordinator on 8/25/16 at 3:00 PM. The 4/11/16 admission MDS assessment for Resident #96 was reviewed with the MDS Coordinator. She indicated the resident interview for daily and activity preferences should have been conducted. 3. Resident # 88 was admitted to the facility on 6/24/16 with multiple diagnoses including End Stage Renal Disease (ESRD) and was on hemodialysis. The Admission Minimum Data Set (MDS) assessment dated 7/1/16 indicated that Resident #88's cognition was intact and she had received dialysis while a resident at the facility. The assessment under the area of height was not completed with dashes on the box. An interview was conducted with the Administrator on 8/25/16 at 2:53 PM. She indicated her expectation was for the MDS to be fully completed based on the resident's medical record. On 8/25/16 at 3:04 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the height should have been entered on the MDS assessment and not dashes.	F 272	The results of the audit indicated that all heights were documented appropriately. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Moving forward, the facility will utilize Resident Interview Wizard in licensed electronic health record software to complete indicated resident interviews to include residents for customary routine and activities. 100% education of all current nursing staff, to include full time, part time and our as needed nursing staff, will be completed by Director or Nursing, Assistant Director of Nursing and/or RN supervisor on 09/15/2016, 09/16/2016, and 09/19/2016 on obtaining height and on height entry into licensed electronic health record software on admission and annually. Education on obtaining vitals to include height will be included in the new hire orientation packet and will be done annually. The MDS nurse #1 and #2 , Certified Dietary Manager, Director of Social Services and Activities Director were educated by Regional Clinical Director on 9/19/16, regarding completing the Care Area Assessment and accuracy of MDS completion according to RAI guidelines. Monitoring Process: Effective 09/19/2016, prior to submission	

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F 272	Continued From page 14	F 272	Director of Social Services, Activity Director, and/or Certified Dietary Manager will review all comprehensive assessments completed by MDS Nurse #2 to ensure all Care Area Assessments are completed as triggered in Section V. Any Care Area Assessments not completed will be completed prior to submission. These reviews will take place Monday through Friday for 4 weeks on 100% comprehensive assessments completed, 50% of all completed comprehensive assessments weekly for 4 weeks, then 25% of all completed comprehensive assessments monthly for 3 months or until compliance is achieved. Effective 09/19/2016, prior to submission, MDS Nurse #1, MDS Nurse #2 (Whomever is not signing off on the assessment) will review 100% completed MDS assessments (Question K0200) for completion. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. Effective 09/19/2016, prior to submission MDS Nurse #1 and/or MDS Nurse #2 (Whomever is not signing off on the assessment) will review all comprehensive assessments completed by Activities Director to ensure interviews for customary routine and activities are	

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F 272	Continued From page 15	F 272	completed per RAI guidelines. Any interviews not completed will be completed prior to submission. These reviews will take place Monday through Friday for 4 weeks on 100% comprehensive assessments completed, 50% of all completed comprehensive assessments weekly for 4 weeks, then 25% of all completed comprehensive assessments monthly for 3 months or until compliance is achieved. MDS Nurse #1, MDS Nurse #2, Director of Social Services, Activities Director , and/or Certified Dietary Manager will present the findings of this audit, effective 9/22/2016, to the Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is achieved.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		9/22/16

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F 278	Continued From page 16 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, observation, and medical record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of life expectancy (Resident #1), hospice care (Resident #1), respite care (Resident #1), active diagnoses (Residents #1 and #11), medications (Residents #11 and #72), behaviors (Resident #103), dental status (Resident #1), and preferences for customary and routine activities (Resident #96) for 5 of 26 sampled residents. The findings included: 1. Resident #1 was initially admitted to the facility on 3/3/15 and readmitted to the facility on 7/22/16 with multiple diagnoses that included end stage renal disease, respiratory failure, heart failure, chronic obstructive pulmonary disease, and anxiety. 1a. A nursing note dated 7/22/16 indicated Resident #1 was followed by hospice care.	F 278	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: 1. Resident # 1 1a. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on	

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F 278	Continued From page 17 The admission Minimum Data Set (MDS) dated 7/29/16 indicated Resident #1 was cognitively intact. Section J, the Health Conditions section, had not indicated Resident #1 had a life expectancy of six months or less (Question J1400). A review of the medical record revealed hospice progress notes dated 7/22/16 through 8/23/16 for Resident #1. An interview with Resident #1 was conducted on 8/23/16 at 4:45 PM revealed she had received hospice services prior to her admission through present (8/23/16). An interview was conducted with the Administrator and the MDS Coordinator on 8/24/16 at 9:50 AM. Both the Administrator and MDS Coordinator indicated Resident #1 was not on hospice. The hospice progress notes, dated 7/22/16 through 8/23/16, for Resident #1 that were located in the hard copy medical record were reviewed with the Administrator and MDS Coordinator. The Administrator indicated she needed to follow up with the hospice provider to confirm if Resident #1 was on hospice services. An interview was conducted with the facility Nurse Consultant and the Administrator on 8/24/16 at 10:45 AM. The facility Nurse Consultant indicated the hospice provider confirmed Resident #1 had received hospice services prior to admission and continued to receives services through present (8/24/16). He revealed the MDS was coded inaccurately for life expectancy. A follow up interview was conducted with the	F 278	08/24/2016 to indicate in Question J1400 that resident had life expectancy of 6 months. 1b. Minimum Data Set dated 7/29/16 was modified by MDS Nurse #1 on 08/24/2016 to indicate in Question O0100 K 1 and 2 modified to indicate resident was receiving Hospice services while not a resident and while a resident. 1c. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on 08/24/2016 to indicate in Question O0100L modified to indicate resident was admitted for respite services while a resident. 1d. Minimum data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on 08/24/2016 to indicate in Section I, to include anxiety as an active diagnosis. 1e. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse # 1 on 08/24/2016 to indicate in Question L0200, that resident had no natural teeth. 2. Resident #11 2a. Minimum Data Set dated 7/13/16 was modified/corrected by MDS Nurse #1 on 09/17/2016 to indicate in question N0410, the correct number of days of use of antipsychotic medications in 7 day look back period. 2b. Minimum Data Set dated 7/13/16 was modified/corrected by MDS Nurse #1 on 09/17/2016 to indicate in Section I , the correct active diagnosis. 3. Resident #96 is no longer at the facility. 4. Resident #72 4a. Minimum Data Set dated 7/25/16 was modified/corrected by MDS Nurse #1 on	

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F 278	Continued From page 18 Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record. 1b. A nursing note dated 7/22/16 indicated Resident #1 was followed by hospice care. The admission Minimum Data Set (MDS) dated 7/29/16 indicated Resident #1 was cognitively intact. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #1 had not received hospice care while not a resident (Question O0100K1) and had not received hospice care while a resident (Question O0100K2). A review of the medical record revealed a hospice progress notes dated 7/22/16 through 8/23/16 for Resident #1. An interview with Resident #1 was conducted on 8/23/16 at 4:45 PM revealed she had received hospice services prior to her admission through present (8/23/16). An interview was conducted with the Administrator and the MDS Coordinator on 8/24/16 at 9:50 AM. Both the Administrator and MDS Coordinator indicated Resident #1 was not on hospice. The hospice progress notes, dated 7/22/16 through 8/23/16, for Resident #1 that were located in the hard copy medical record were reviewed with the Administrator and MDS Coordinator. The Administrator indicated she needed to follow up with the hospice provider to confirm if Resident #1 was on hospice services. An interview was conducted with the facility Nurse	F 278	09/17/2016 to indicate in question N0410, the correct number of days of antibiotic received. 5. Resident #103 is no longer at the facility. Corrective actions will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have potential to be affected. 100% of current residents will be audited by Director of Social Services to determine if they are receiving Hospice Services and Respite Services. The results of the audit indicated that no other residents were hospice or respite services. 1a. 100% of residents on hospice services were audited by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 for accuracy on Question J1400,Prognosis. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. The results of the audit indicated that all residents currently on hospice were coded correctly under Question J1400. 1b. 100% of residents on hospice services were audited by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 for accuracy in Question O0100K, Hospice Care while not a resident and while a resident. Modifications/corrections done to Minimum Data Set as indicated	

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F 278	Continued From page 19 Consultant and the Administrator on 8/24/16 at 10:45 AM. The facility Nurse Consultant indicated the hospice provider confirmed Resident #1 had received hospice services prior to admission and continued to receives services through present (8/24/16). He revealed the MDS was coded inaccurately for hospice care while not a resident and hospice care while a resident. A follow up interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record. 1c. A nursing note dated 7/22/16 indicated Resident #1 was admitted to the facility for respite care. A review of the medical record revealed a hospice progress note dated 7/22/16 for Resident #1 that indicated she was at the facility for a respite stay. The admission MDS dated 7/29/16 indicated Resident #1 was cognitively intact. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #1 had not received respite care while a resident at the facility (Question O0100L2). An interview with Resident #1 was conducted on 8/23/16 at 4:45 PM revealed she was admitted to the facility on 7/22/16 for a respite stay. She indicated the plans had changed and she was now long term care. An interview was conducted with the Administrator and the MDS Coordinator on	F 278	per RAI guidelines. The results of the audit indicated that all residents currently on hospice were coded correctly under Question O0100K. 1c. 100% audit of residents on respite care were conducted by MDS Nurse #1 and #2 on 09/16/16, 09/17/16, and 09/18/16 to ensure that all residents admitted for respite care were coded accurately in Question O0100L, Respite Care. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. At the time of audit no residents were currently on respite care. 1d. 100% audit of all active resident's most recent MDS assessment was conducted by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 to ensure all active diagnoses were coded appropriately in section I, Oral/Dental status in question L0200 and number of days resident received antipsychotic medication and antibiotic therapy in the seven day look back period on question N0410A and N0410F consecutively per RAI guideline. The audit will also include rejection of care coding in question E0800 as per RAI guideline. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. The active diagnosis audit for Section I revealed 9 other assessments were coded incorrectly. The audit of Question L0200 revealed no other coding errors.	

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F 278	Continued From page 20 8/24/16 at 9:50 AM. Both the Administrator and MDS Coordinator indicated they had not known if Resident #1 was admitted to the facility for a respite stay. The nursing progress note, dated 7/22/16, for Resident #1 that indicated she was admitted for a respite stay was reviewed with the Administrator and MDS Coordinator. The Administrator indicated she needed to look into the issue to determine if Resident #1 was admitted to the facility for respite care. The MDS Coordinator indicated she had not known what section the question about respite care was located. An interview was conducted with the facility Nurse Consultant and the Administrator on 8/24/16 at 10:45 AM. The facility Nurse Consultant indicated Resident #1 was admitted to the facility 7/22/16 for a respite stay. He revealed the MDS was coded inaccurately respite care. A follow up interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record. 1d. A physician's order for Resident #1 dated 7/22/16 indicated Clonazepam (antianxiety medication) as needed (PRN) for anxiety. The July 2016 Medication Administration Record (MAR) indicated Resident #1 was administered the PRN Clonazepam on 7/24/16. The admission MDS dated 7/29/16 indicated Resident #1 was cognitively intact. Section I, the Active Diagnoses section, was not coded for anxiety (Question I5700).	F 278	The antipsychotic medication audit revealed 4 other assessments were coded incorrectly. The antibiotic audit revealed 1 other assessment was coded incorrectly. The rejection of care audit revealed no other residents were not coded for rejection of care. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Regional Clinical Director revised the "MDS data collection tool" on 9/19/2016. Effective 09/20/2016 MDS Nurse #1 & 2 will utilize revised data collection tool to collect all necessary information needed for accurate coding of MDS assessment. This tool will be maintained in a designated area in the facility for 15 months with other MDS materials. The MDS nurse #1 and #2 , Certified Dietary Manager, Director of Social Services and Activities Director were educated by Regional Clinical Director on 9/19/16, regarding completing the Care Area Assessment and accuracy of MDS completion according to RAI guidelines. Monitoring Process: Effective 09/19/2016, prior to submission, Director of Social Services and/or Activities Director will review completed MDS Assessment by MDS Nurse #1 or MDS Nurse #2 to ensure Question J1400, Question O0100K, Question O0100L, Section I, Question LO200, Question N0410, and Question E0800 are coded	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 21 An interview was conducted with the Administrator and the MDS Coordinator on 8/24/16 at 9:50 AM. The Active Diagnoses section of Resident #1's 7/29/16 admission MDS was reviewed with the Administrator and MDS Coordinator. Anxiety was not indicated as an active diagnosis for Resident #1 on the 7/29/16 admission MDS. The physician's order dated 7/22/16 for PRN Clonazepam for anxiety was reviewed with the Administrator and MDS Coordinator. The July 2016 MAR that indicated Resident #1 was administered PRN Clonazepam once during the look back period of the 7/29/16 admission MDS was reviewed with the Administrator and MDS Coordinator. The MDS Coordinator indicated there was an active diagnosis of anxiety for Resident #1 during the 7/29/16 MDS look back. She revealed the MDS was coded incorrectly and should have indicated anxiety as active diagnosis for Resident #1. A follow up interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record. 1e. A nursing note dated 7/22/16 indicated Resident #1 had no natural teeth. The admission MDS dated 7/29/16 indicated Resident #1 was cognitively intact. Section L, the Oral/Dental Status section, indicated Resident #1 had no dental issues. An interview with Resident #1 was conducted on 8/23/16 at 4:45 PM. Resident #1 stated she had no natural teeth.	F 278	accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. Effective 09/19/2016, prior to submission, MDS Nurse #1 and/or MDS Nurse #2 (Whomever is not signing off on the assessment) will review completed MDS assessment to ensure question E0800 is coded accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. MDS nurse #1, MDS nurse #2, Director of Social Services, and/or Activities Director will present the findings of this audit, effective 9/22/2016, to the Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is achieved.	

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An observation of Resident #1 was conducted on 8/23/16 at 4:46 PM revealed Resident #1 had no natural teeth.

An interview was conducted with the Administrator and MDS Coordinator on 8/24/16 at 9:50 AM. The Oral/Dental Status section of Resident #1's 7/29/16 admission MDS was reviewed with the Administrator and MDS Coordinator. The nursing note dated 7/22/16 that indicated Resident #1 had no natural teeth was reviewed with the Administrator and MDS Coordinator. The resident interview with Resident #1 and the observation of Resident #1 from 8/23/16 that indicated she had no natural teeth was reviewed with the Administrator and MDS Coordinator. The MDS Coordinator indicated the 7/29/16 MDS for Resident #1 was coded inaccurately and should have indicated she had no natural teeth.

A follow up interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record.

2. Resident #11 was admitted on 12/12/13 with multiple diagnoses that included major depressive disorder, anxiety disorder, and dementia with behavioral disturbance.

2a. A physician ' s order for Resident #11 dated 1/29/16 indicated Seroquel (antipsychotic medication) 25 milligrams (mg) in morning and 50mg at night.

The annual MDS dated 7/13/16 indicated

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Resident #11 had moderate cognitive impairment. She was indicated to have received antipsychotic medications on 0 of 7 days during the 7/13/16 MDS look back period.

The July 2016 Medication Administration Record (MAR) for Resident #11 indicated she was administered Seroquel on 7 of 7 days during the 7/13/16 MDS look back period.

An interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record.

An interview was conducted with the MDS Coordinator on 8/25/16 at 3:00 PM. The MDS Coordinator reviewed the 7/13/16 annual MDS for Resident #11. She indicated the MDS was coded inaccurately for antipsychotic medications.

2b. A physician's order for Resident #11 indicated Cymbalta (antidepressant medication) 60mg daily.

A pharmacy consultation note dated 5/26/16 indicated Resident #11 received Cymbalta for anxiety and major depressive disorder.

A physician's progress note dated 5/30/16 indicated Resident #11 had a diagnosis of major depression.

A physician's note dated 6/7/16 indicated Resident #11 had the diagnoses of anxiety, dementia with behavioral disturbance, and depression.

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A pharmacy consultation note dated 6/28/16 indicated Resident #11 continued on Cymbalta for anxiety and major depressive disorder.

The annual MDS dated 7/13/16 indicated Resident #11 had moderate cognitive impairment and she received antidepressant medications on 7 of 7 days during the MDS look back period. Depression was not indicated as an active diagnosis.

An interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record.

An interview was conducted with the MDS Coordinator on 8/25/16 at 3:00 PM. The MDS Coordinator reviewed the 7/13/16 annual MDS for Resident #11. She indicated the MDS was coded inaccurately for active diagnoses.

3. Resident #96 was admitted on 4/4/16 with multiple diagnoses that included multiple sclerosis.

A nursing note dated 4/11/16 indicated Resident #96 was alert and oriented and was able to make her needs known to staff.

A social service note dated 4/11/16 indicated Resident #96 was alert and verbal, she was able to make her needs known, and she was able to make daily decisions.

The admission MDS for Resident #96 dated 4/11/16 indicated she had moderate cognitive impairment, adequate hearing, clear speech, was

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usually understood and understood others. Section F, the Preferences for Customary and Routine Activities section, indicated the resident interview was not conducted because Resident #96 was rarely/never understood (Question F0300).

An interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for the MDS to be coded accurately based on the resident's medical record.

An interview was conducted with the MDS Coordinator on 8/25/16 at 3:00 PM. The 4/11/16 admission MDS assessment for Resident #96 was reviewed with the MDS Coordinator. She indicated Question F0300 was answered incorrectly on Resident #96's 4/11/16 admission MDS.

4. Resident #72 was admitted to the facility 2/12/13 and readmitted on 5/30/16. Cumulative diagnoses included: chronic ischemic heart disease, diabetes, dementia without behavioral disturbance and urinary tract infection (5/20/16).

A Quarterly Minimum Data Set (MDS) dated 7/25/16 indicated Resident #72 was severely impaired in cognition. Medications administered during the seven day look-back period included seven (7) days of antibiotics.

A review of the July Medication Administration Record (MAR) for the look back period 7/1916 through 7/25/16 revealed Resident received the antibiotic (Cipro) on 7/19/16 (one day).

On 8/25/16 at 3:14PM, an interview was conducted with the MDS Coordinator. She stated

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she did not know why antibiotics was coded as having been received for seven days.

On 8/25/16 at 3:15PM, an interview was conducted with the Administrator who stated she expected the MDS to be accurate and complete per the clinical record.

5. Resident #103 was admitted to the facility 8/28/12 and discharged to the hospital 3/28/26. Cumulative diagnoses included, in part, cerebrovascular accident with hemiplegia (partial loss of function) on the dominant side, diabetes mellitus, multiple joint contractures, coronary artery disease, hypertension, chronic obstructive pulmonary disease, hypothyroidism, esophageal reflux and chronic kidney disease.

A Quarterly Minimum Data Set (MDS) dated 3/16/16 indicated Resident #103 was cognitively intact. Moods noted feeling tired, no energy nearly every day. No behaviors were noted.

A review of the bath report roster for Resident #103 for the look back period for behaviors (3/10/16 through 3/16/16) revealed the following: 3/12/16 resisted care--nurse notified; 3/16/16 resisted care--nurse notified.

On 8/25/16 at 11:12AM, an interview was conducted with Nursing Assistant (NA) #1. He stated he remembered Resident #103 and usually provided care for Resident #103 in the evenings. He stated Resident #103 was scheduled to receive his showers during the evening shift twice a week and refused the showers the majority of the time. NA#1 stated Resident #103 would refuse to have a bed bath at times also. NA #1 stated when it was

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F 278	Continued From page 27 documented " resisted care " , it meant Resident #103 refused care. On 8/25/2016 at 3:16PM, an interview was conducted with the MDS Coordinator who stated she reviewed the nursing notes when she completed the MDS section for behaviors. She was unaware of the shower/ bath refusals. On 08/25/2016at 3:18PM, an interview was conducted with the Administrator who stated she expected the MDS to be accurate and complete per the clinical record.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/22/16

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F 279	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and medical record review, the facility failed to develop a plan of care with measurable goals to address the care and treatment related to hospice for 1 of 5 residents reviewed for unnecessary medications (Resident #1). The findings included: Resident #1 was initially admitted to the facility on 3/3/15 and readmitted to the facility on 7/22/16 with multiple diagnoses that included end stage renal disease, respiratory failure, heart failure, chronic obstructive pulmonary disease, and anxiety. A nursing note dated 7/22/16 indicated Resident #1 was followed by hospice care. A review of the medical record revealed hospice progress notes dated 7/22/16 through 8/23/16 for Resident #1. The admission Minimum Data Set (MDS) dated 7/29/16 indicated Resident #1 was cognitively intact. Resident #1 was not coded as hospice. The comprehensive plan of care for Resident #1 initiated on 8/5/16 and most recently updated on 8/8/16 had not included a care plan for hospice. A nursing note dated 8/13/16 indicated Resident #1 was on hospice services. A pharmacy consultation note dated 8/18/16 indicated Resident #1 was on hospice services. An interview with Resident #1 was conducted on	F 279	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #1 had care plan updated on 8/24/2016, to reflect antidepressant medications and associated hospice care. This was completed by MDS nurse #1. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Effective 09/19/2016, the Regional Clinical Director revised Admission/Readmission communication form to include a section for pre-admission screening. 100% audit for all residents receiving hospice services and who are followed by the Program of All- Inclusive Care for the Elderly (PACE) completed by the Director of Social Services, & MDS nurse #1 and MDS nurse #2 on 9/16/2016. This audit	

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F 279	Continued From page 29 8/23/16 at 4:45 PM. Resident #1 revealed she had received hospice services prior to her admission through present (8/23/16). An interview was conducted with the Administrator and MDS Coordinator on 8/24/16 at 9:50 AM. Both the Administrator and MDS Coordinator indicated Resident #1 was not on hospice. The hospice progress notes, dated 7/22/16 through 8/23/16, for Resident #1 that were located in the hard copy medical record were reviewed with the Administrator and MDS Coordinator. The Administrator indicated she needed to follow up with the hospice provider to confirm if Resident #1 was on hospice services. An interview was conducted with the facility Nurse Consultant and the Administrator on 8/24/16 at 10:45 AM. The facility Nurse Consultant indicated the hospice provider confirmed Resident #1 had received hospice services prior to admission and continued to receives services through present (8/24/16). He indicated Resident #1 was initially admitted for a short term respite stay. He stated she had converted to long term care after admission. He indicated Resident #1 was also followed by a community healthcare program that coordinated services with the hospice provider. He stated that coordinating care with the community healthcare program was new process for the facility and that may have contributed to the confusion with whether or not Resident #1 had received hospice services. He revealed there was a breakdown in the system that needed to be corrected. He indicated this was why there was no care plan for hospice for Resident #1. He indicated the MDS Coordinator was in the process of initiating a care plan for hospice for Resident #1.	F 279	focus was on ensuring each resident who receives Hospice services has an up to date care plan in place. The audit revealed no other residents failed to have a hospice plan of care in place. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Effectively 09/19/2016 The Admission Director or Business Office Manager will complete pre-admission screening for all residents admitted to the facility and followed by the Program of All- Inclusive Care for the Elderly (PACE). The screening will identify program and services received by the resident before admission in the community, that will continue to be rendered at the facility to include but not limited to Hospice care. The Admission Director or Business Office Manager will receive such information by contacting the referring agent via phone, fax or E-mail, and document her findings on the “Admission/Readmission communication form” Effective 09/19/2016, the admitting nurse will write a Hospice Care order for any new admit/readmit indicated on the “Admission/Readmission communication form” to have Hospice care, and interim care plan for Hospice will be generated. Effective 09/19/16, Director of Nursing,	

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F 279	Continued From page 30 A final interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for care plans to be accurate based on the resident ' s medical record.	F 279	Assistant Director of Nursing and/or MDS nurse will review physician orders at the Monday thru Friday clinical meeting for the need to update or initiate care plans. Upon findings, appropriate care plans will be updated and or initiated, especially for orders involving Hospice Services. Any identified Hospice order will be documented on “Daily Priority List form” with findings and action taken. On 09/16/2016; Regional Clinical Director re-educated MDS nurse #1, MDS nurse #2, Director of Social Services, Activities Director, Director of Nursing and Assistant Director of nursing and Certified Dietary manager on how to, and when to, develop a care plan for any resident in the facility. Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will complete 100% education on the revised facility care plan development process for all licensed nurses. This education will be completed by 09/22/2016. Any Licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. Education on the facility care plan development process is added on new hires orientation education for all new licensed nurses. This education will also be provided annually for all Licensed nurses. Monitoring Process Director of Social Services or Activities Director will review new admission/readmission communication forms for all new admits/readmits to	

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F 279	Continued From page 31	F 279	ensure all residents indicated to have Hospice care have the Hospice order and care plan. This audit will be done daily (Monday thru Friday) x 4 weeks then weekly x 4 weeks and monthly x 3 months or until the pattern of compliance is maintained. Effective 09/22/2016, prior to submission, Director of Social Services and/or Activities Director will review completed MDS Assessment by MDS Nurse #1 or MDS Nurse #2 to ensure antidepressant medications are care planned when indicated. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. Director of Nursing, Assistant Director of Nursing, Nursing Supervisor as well as MDS Nurse (#1 & #2), will monitor compliance of care plan development by conducting clinical meeting daily (M-F), effective 9/19/2016, this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure care plans are developed and updated timely. Findings from this meeting will be documented on a daily	

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F 279	Continued From page 32	F 279	priority list form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of priority list weekly x 4 weeks, then monthly x 3 months. Director of Nursing will report findings to facility Quality Assurance Performance improvement Committee for any additional monitoring needs or alteration of this requirement.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		9/22/16

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F 280	Continued From page 33 by: Based on observation, staff interview, and medical record review the facility failed to review and revise plans of care in the areas of intravenous (IV) fluids (Resident #147) and nutrition (Resident #72) for 2 of 26 sampled residents. The findings included: 1. Resident #147 was admitted to the facility on 2/19/16 with multiple diagnoses that included diabetes mellitus, hypertension, and hyperlipidemia. The quarterly Minimum Data Set (MDS) assessment dated 5/20/16 indicated Resident #147 was cognitively intact. She was coded as having received a therapeutic diet and IV feeding during the 7 day MDS review period. A physician's order dated 5/20/16 indicated IV fluids for Resident #147 due to her experiencing nausea and vomiting and unable to take in oral food or fluids. A plan of care was initiated on 5/22/16 for Resident #147 that indicated she was at risk for an alteration in fluid volume and required IV fluid due to nausea and vomiting. The interventions included: monitor IV site every shift, administer IV fluids or parenteral nutrition as ordered, obtain labs as ordered, and monitor for changes in symptoms. A physician's order dated 5/23/16 indicated a discontinuation of IV fluids for Resident #147. On 8/18/16 the plan of care for IV fluids for Resident #147 was reviewed by the MDS Coordinator. The MDS Coordinator documented	F 280	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F280 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #147 care plan for intravenous (IV) fluid discontinued by the MDS coordinator on 8/25/2016. Resident #72 nutrition care plan reviewed and revised and "no straw" removed from care plan on 08/25/2016. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 100% of audit for current residents completed on 09/16/2016, 09/17/16, and 9/18/2016, by the Director of Nursing, Assistant Director of Nursing, MDS nurse #1 and MDS nurse #2 to identify any other residents who have had an order for intravenous fluid in the last 12 months, to	

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F 280	Continued From page 34 on Resident #147's hard copy care plan for IV fluids, "8/18/16 [plan of care] reviewed - updated x 90 days - 11/18/16". The care plan was signed by the MDS Coordinator. An observation of Resident #147 on 8/22/16 at 3:44 PM revealed no utlization of IV fluids. An interview was conducted with the Administrator on 8/24/16 at 5:39 PM. She indicated her expectation was for care plans to be reviewed and revised based on the resident's medical record. An interview was conducted with Nurse #1 on 8/25/16 at 9:45 AM. Nurse #1 stated she had worked at the facility for about a month. She indicated she was familiar with Resident #147. She stated Resident #147 had not received IV fluids since her time working at the facility. An interview was conducted with the MDS Coordinator on 8/25/16 at 3:15 PM. She indicated the care plan related to IV fluids for Resident #147 was discontinued as of that morning (8/25/16). Surveyor: Calder, Noreen 2. Resident #72 was admitted to the facility 2/12/13 and readmitted on 5/30/16. Cumulative diagnoses included: dementia without behavioral disturbance and dysphagia (difficulty swallowing). A Significant Change Minimum Data Set (MDS)	F 280	ensure their care plan is revised as appropriately. The audit revealed that 2 other residents had IV fluids ordered in the last twelve months but did not have a care plan for the IV fluids. 100% audit of current residents completed on 09/16/2016, 09/17/16 and 9/18/2016, by the Director of Nursing, Assistant Director of Nursing, MDS nurse #1 and MDS nurse #2 to identify any other residents with adaptive eating devices, and/or any restrictions of not using straw The audit revealed 11 other residents had adaptive eating devices that were not updated on their care plan. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: The Regional Clinical Director re-educated MDS nurses (#1 & #2), Social Services Director, and nursing administrative staff on how to review, revise and update Care Plan in a timely manner. This re-education was conducted on 9/19/2016. Moving forward licensed nurses are also expected to update care plans with new approaches as changes arise, effective 09/20/2016. Director of Nursing, Assistant Director of Nursing or RN Supervisor will complete	

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F 280	Continued From page 35 dated 6/6/16 indicated Resident #72 was severely impaired in cognition. He required extensive assistance with eating. A review of a care plan dated 6/6/16 and last reviewed and revised 7/14/16 stated Resident #72 was at risk for altered nutrition secondary to being on a mechanically altered/therapeutic diet with honey thickened liquids. Approaches included, in part, No straws. A dining observation was conducted on 8/24/16 at 8:40AM. Resident #72 was sitting in the main dining room and was not feeding himself. Nursing staff sat down and assisted him with his meal. Straws were used for his thickened liquids. A review of physician orders was conducted and revealed a physician's dated 6/28/16 that stated downgrade diet per daughter/ responsible party request to nectar thickened liquids. Continue mechanical soft foods. D/C (Discontinue) no straws as patient can have straws with nectar thickened liquids. There was also a physician's order dated 7/20/16 that stated the following: Diet clarification: mechanical soft, nectar thick liquids. May have straws. On 8/25/16 at 3:19PM, an interview was conducted with the MDS Coordinator who stated she was the one responsible for changes to the care plan. She stated she would receive a copy of the order and review and revise the care plan as needed. She said the care plan should have been updated to reflect Resident #72 no longer needed straws. On 8/25/16 at 3:20PM, an interview was conducted with the Administrator who stated she	F 280	100% education on the revised facility care plan updating process for all licensed nurses will be completed by 09/22/2016. Any Licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. Education on the facility care plan updating process is added to the new hires orientation education for all new licensed nurses. This education will also be provided annually for all Licensed nurses. Monitoring Process Director of Nursing, Assistant Director of nursing, Nursing Supervisor as well as MDS nurse (#1 & #2), will monitor compliance of care plan update by conducting clinical meeting daily (Monday-Friday), effective 9/20/2016, this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure care plans are developed and updated timely. Findings from this meeting will be documented on a daily priority list form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are completed. Director of nursing will review the completion of priority list weekly x 4 weeks, then monthly x 3 months. Director	

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F 280	Continued From page 36 expected the care plan to be accurate, reviewed and revised based on the resident's medical record.	F 280	of Nursing will report findings to facility Quality Assurance Performance improvement Committee for any additional monitoring needs or alteration of this requirement.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, hospice provider interview, observation and record review the facility failed to have effective communication between the facility and the hospice provider and failed to have a hospice care plan from the hospice provider at the facility for 1 of 1 sampled residents reviewed for hospice services (Resident #155). The findings included: Resident #155 was admitted 10/1/15 and had cumulative diagnoses including dementia, hypertension and contractures. Resident #155 was admitted to hospice services on 10/28/15. Review of the Care Plan updated 6/24/16 revealed that the plan of care for continuation of hospice services included the following interventions: assist with set up of hospice, coordinate care with hospice team, pain management, and provide me and family with grief and spiritual counselling if required. Further	F 309	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective action accomplished for those residents found to have been affected by the alleged deficient practice:	9/22/16

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F 309	Continued From page 37 review of the Medical Record revealed there were hospice progress notes from the Hospice Provider but there was not a hospice care plan, from the hospice provider, in Resident #155 ' s Medical Record. On 8/25/16 at 9:00 AM Nurse #5 was observed during medication pass. She was observed to dispense a medication from a medication blister pack stored in the controlled drug lock box of the medication lock box and then return the blister pack to the lock box of the medication cart. Nurse #5 was asked to reopen the lock box so the blister pack she dispensed the medication from could be observed. She located the blister pack and confirmed that the medication dispensed was Lorazepam (a medication for anxiety) 1 mg (milligram). Upon confirming this, Nurse #5 indicated that she thought the Lorazepam must be a prn (as needed) medication for Resident #155 but that what she had been wanting to dispense to the resident was her scheduled dose of 0.25 mg Xanax (antianxiety medication). Nurse #5 looked in the controlled drug lock box at that time but was unable to locate Xanax for Resident #155. She then indicated she needed to make some calls to sort out the discrepancy. On 8/25/16 at 9:14 AM Nurse #5 was interviewed and stated that she called the pharmacy for the Resident and was told that the hospice physician sent a prescription to the pharmacy for Resident #155 to have Lorazepam 1 mg so that was what the pharmacy sent to the facility. She added that after she talked to the pharmacy they faxed her the prescription from the hospice physician. Nurse #5 indicated that there had been a communication breakdown with the hospice	F 309	Resident #155 Hospice care plan retrieved from the Hospice company on 9/14/2016 by the director of social services and filed in resident's medical records. Resident #155 order for Lorazepam 1 mg discontinued by facility physician on 8/25/2016 and. Order for Xanax 0.25mg by mouth three times daily received on 8/25/2016. Resident #155 medications reviewed and reconciled by hospice nurse and the Director of Nursing on 09/19/2016 to ensure accuracy. Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice: 100% audit for all hospice residents completed by the Medical Record personnel, on 09/19/2016 to identify any other residents with no hospice care plan in active records, findings documented on "Hospice record audit form" and discrepancies addressed immediately by contacting the hospice company. The audit revealed that all other hospice residents had a hospice care plan. Medication review for each hospice resident will be completed by the Hospice nurses on 09/16/2016, 09/19/2016 and 09/20/2016 to ensure each resident medication profile matches between the	

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F 309	Continued From page 38 provider because the hospice provider had not informed the facility of the order change and therefore the facility did not have an order to give Resident #155 Lorazepam 1 mg. Nurse #5 stated that since she now had a copy of the prescription from the hospice physician she was going to call the facility physician to get a new order for Resident #155 to have the Lorazepam 1 mg scheduled, instead of the Xanax 0.25 mg. On 8/25/16 at 9:16 AM the Hospice Nurse (HN #1) listed in the resident ' s medical record was called and interviewed. She stated that she had just taken over the care for Resident #155 about a week ago from another hospice nurse and did not know much about the situation. She indicated that she was not aware the facility had not been informed of the medication change and was not sure of the particulars regarding why the medication was changed. She thought perhaps the hospice physician ' s nurse had sent the prescription to the pharmacy but that she (HN #1) had not been aware of it so could not call in a verbal order to the facility. HN #1 stated she had been in the facility to see the resident once and had talked to staff at the facility but did not know the hospice provider care plan was not in the resident ' s medical record at the facility but said she would bring a copy for the residents Medical Record at the facility. On 8/25/16 at 9:20 AM Nurse #5 stated that the facility physician stated that he wanted to discontinue the Lorazepam 1 mg for Resident #155 and keep her on the scheduled Xanax 0.25 mg. She added that since she did not currently have the resident ' s scheduled Xanax she was going to call the pharmacy to have it sent from the pharmacy back up to obtain it quickly.	F 309	facility records and Hospice medical records. Medication review for each hospice resident revealed that all hospice residents medications were up-to-date. Measures put into place to ensure that the alleged deficient practice will not recur: Moving forward all hospice care plans will be filed within one week of residents admission to hospice in each resident's active medical record. Effective 09/19/2016 Administrator, Director of Nursing, and the Director of Social Services together with the Regional Clinical Director met with Hospice team to include Hospice nurse, Hospice Social worker and Hospice Liaison for 1 of 3 companies that provide care and services in the facility on 09/14/2016 to discuss best practices on collaboration of care between the facility and the Hospice Company. Administrator, Director of Nursing, and the Director of Social Services will meet with the other two companies no later than 09/22/2016 to discuss best practices on collaboration of care between the facility and the Hospice Company. This meeting will be led by the facility Administrator. Hospice admission communication form created on 09/19/2016 by the Regional Clinical Director. This communication form will be completed by the admitting	

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F 309	Continued From page 39 On 8/25/16 at 2:30 PM the Administrator was interviewed and stated that she expected the hospice provider to coordinate care with the facility and ensure new orders were communicated.	F 309	hospice nurse for residents that elect hospice care. Copies of this communication form will be provided to Business office Manager, MDS nurses, and Director of nursing via facility mailboxes currently located near the Administrator's office. Effective 09/20/2016 any newly admitted resident to hospice services will be communicated in the morning on the next business day after being admitted to Hospice Services. On 09/20/2016, Facility Administrator educated the Admission Director, Business office manager, Director of Social Services, MDS nurse # 1 and MDS nurse # 2, Director of Nursing and Assistant Director of nursing on how communication will flow when a resident is admitted to the facility under Hospice care or when a resident elect to be under Hospice services while in the facility. 100% education of all licensed nursing staff, to include full time, part time and our as needed nursing staff, will be completed by the Director of Nursing, Assistant Director of Nursing and or Director of Social Services. This educated will focus on how to ensure; 1. Proper communication between hospice providers and the facility is maintained 2. Hospice care plans are maintained in resident's medical records 3. How to get in touch with the hospice providers.	

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F 309	Continued From page 40	F 309	This education will be completed by 09/21/2016, any licensed nurse not educated by 09/21/2016 will not be allowed to work until educated. Monitoring Process; Director of social services or Medical Record Personnel will audit each hospice resident's health record daily (Monday through Friday) x 4 weeks to ensure Hospice care plans are in place. Director of nursing or Assistant Director of Nursing will audit each hospice resident's medication profile once a week x4 weeks then monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will be reported to the facility quality assurance and Performance improvement committee by the Director of nursing or Director of Social services member for further monitoring needs or changes of the plan.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, observation and record review the facility failed to	F 312	This plan of correction constitutes a written allegation of compliance.	9/22/16

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F 312	Continued From page 41 shave a male resident while providing activities of daily living care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). The findings included: Resident #22 was admitted 8/14/14 with cumulative diagnoses including diabetes, neuropathy, osteoarthritis and glaucoma. The most recent Minimum Data Set (MDS) assessment an annual assessment indicated the resident was moderately cognitively impaired and required extensive assistance of one person for hygiene. Review of the care plan dated 6/14/16 revealed a plan of care for activities of daily living with an intervention that indicated the resident required staff assistance for all activities of daily living. On 8/23/16 at 9:30 AM an attempt was made to interview Resident #22 in his room. The staff member in the room (unknown) indicated Resident #22 was receiving patient care t that time. On 8/23/16 at 10:26 AM Resident #22 was observed up in his wheelchair. He was observed to have facial hair stubble that appeared to be one day of growth or greater. Resident #22 stated he was aware of his unshaven facial hair and said that he preferred to be shaved daily. He added that staff typically did not offer to shave him but that sometimes he would ask. On 6/23/16 at 4:44 M Resident #22 was observed up in his wheelchair in his room. He continued to have facial hair stubble on observation.	F 312	Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective Action will be accomplished for the resident found to have been affected by the deficient practice: Resident #22 was shaved on 09/19/2016 by assigned nursing assistant. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All resident have potential to be affected. 100% choices and preferences audit completed by the Director of Social Services on 09/15/2016 & 09/16/2016 to determine each residents choices and preferences, specifically in relation to walking. Non-interview able resident's choices and preferences were done by interviewing power of attorney and or guardian. Findings of this audit are documented on "Resident Choices Audit tool". At the time of the audit, all shaving was	

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F 312	Continued From page 42 On 8/25/16 at 9:09 AM Resident #22 was observed up in his wheelchair and dressed for the day. During interview he indicated that staff were providing him with his showers on Mondays and Thursdays but were not shaving him daily. He indicated he had not been shaved yet this week and preferred to be shaved daily. He was observed to have facial stubble consistent with the facial hair observation on 8/23/16. On 8/25/16 at 1:52 PM Nursing Assistant #5 was interviewed. She indicated that if residents had facial hair that was noticeable she would offer to shave them She also stated that she had told Resident #22 earlier that morning that she would shave him but she had not had time to do it as yet. On 8/25/16 at 2:30 PM the Administrator was interviewed. She indicated that it was her expectation that a resident with visible facial hair be shaved daily if they wanted to be shaved daily. She also stated that she was aware Resident #22 liked to be well groomed and added that his family came in at least weekly to cut his hair and shave him.	F 312	current. 100% grooming audit completed by Restorative aides on all residents to identify any other resident who may be require shaving. This audit was completed on 09/16/16, 09/17/16 and 09/18/16. Any findings will be addressed promptly. Measures put in place or systematic changes made to sure that the deficient practice will not re-occur: Effective 9/22/16, Resident choices and preferences to include choices for shaving will be assessed on admission/readmission, quarterly and with significant changes on “Choices and Preference tool” by Director of Social Services or Activities Director. Any choices and preferences identified by the tool will be implemented as indicated. Effective 09/20/2016, Resident choices and preferences, specifically for shaving will be added on nursing assistants care cards to ensure nursing assistants are aware of each resident’s shaving preferences. Shaving preferences on the CNA care card will be updated based on Choices and preferences assessment completed by the Director of social services or Activities Director, information shared by a resident or family member, or observation made by licensed nurses and administrative staff that may warrant changes on shaving frequency. Effective 09/19/2016, resident’s licensed	

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nurse or certified nursing assistant are expected to identify resident needs for shaving during their shift and offer assistance for shaving as appropriate. Any refusal will be documented in resident's records.

Effective 09/19/2016, Resident grooming status specifically, shaving, is added on the Ambassador rounds worksheet. This will aid identification of shaving needs on a timely manner. Ambassador rounds are conducted by the facility administrative staff to specific assigned room daily (Monday thru Friday). Ambassador rounds findings, specifically shaving needs, will be communicated in a stand up meeting daily for follow ups.

100% residents rights, to include choices and preferences education of all staff, all departments, to include full time, part time and as needed staff, will be completed by the Director of Nursing, Assistant Director of Nursing or Director of Social Services. This education will be completed by 09/22/2016, any current staff not educated bt 9/22/16 will not be allowed to work until completed. This education is also provided for all new hires during the orientation process and will be done annually.

100% education for all licensed nursing staff and nursing assistants, to include full time, part time and as needed staff, on ADL care specifically on how to identify resident's preferences for shaving, as well as how to identify resident who needs

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

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F 312	Continued From page 44	F 312	shaving, and the facility expectation on how to care for dependent residents as it relates to shaving will be completed by the Director of Nursing/Assistant Director of Nursing. This education will be completed by 09/22/2016, any current nursing staff not educated by 9/22/16 will not be allowed to work until educated. This education will be also be provided for all new hires during orientation process and will be done annually, effective 09/22/2016. Monitoring Process: Resident Appointed Ambassadors (Facility Administrative staff) will complete walking rounds daily (Monday thru Friday) to their assigned residents to ensure appropriate care and services are rendered to include shaving. Although, Ambassador program and rounds will continue to take place as part of the facility Quality Assurance and Performance Improvement program, but the documentation of shaving compliance by resident's assigned ambassador will take place daily (Monday thru Friday) x4 weeks, weekly x4 weeks and then monthly for three months or until the pattern of compliance is maintained. Administrator, Director of Nursing and/or Assistant Director of Nursing will conduct walking rounds to include off shifts and weekends to ensure nursing staff are meeting needs of dependent residents involving shaving. These rounds will be completed once a day for 2 weeks, 3x/week for two more weeks, weekly x4 weeks then monthly x 3 months or until	

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F 312	Continued From page 45	F 312	the pattern of compliance is maintained. The Director of Nursing will report findings of walking rounds to Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is obtained.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		9/22/16

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F 329	Continued From page 46 Based on medical record review and staff interview, the facility failed to obtain ordered laboratory work for HgbA1C (glycosylated hemoglobin), keppra level and lipid panel for one of five residents reviewed for unnecessary medication use (Resident #136). The findings included: Lexi-Comp 12th edition of the Geriatric Dosage handbook indicated, in part, monitoring of the fasting lipid panel and blood glucose/ HgbA1C is recommended for residents who receive Seroquel prior to treatment, at three months and at least annually. Resident #136 was admitted to the facility 3/12/15. Cumulative diagnoses included: dementia without behavioral disturbance, hypertension, hyperlipidemia (elevated cholesterol and triglyceride levels) and seizure disorder. A Quarterly Minimum Data Set (MDS) dated 7/21/16 indicated Resident #136 was severely impaired in cognition. Active diagnoses included, in part, hypertension, hyperlipidemia, non-Alzheimer ' s dementia, psychotic disorder and seizure disorder. A care plan dated 2/18/16 and last reviewed 7/14/16 stated Resident #136 was at risk for side effects from antipsychotic and antidepressant drug use. Approaches included, in part, Obtain lab work as ordered by the physician and report results when available. A review of physician ' s orders for August 2016 revealed Resident #136 received the following medications: Keppra (seizure medication) 500	F 329	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F329 Corrective Action will be accomplished for the resident found to have been affected by the deficient practice: Resident #136 laboratory work to include HbA1C (glycosylated hemoglobin), Keppra level and Lipid Panel obtained on 08/24/16 by the contracted licensed laboratory company, result communicated to MD and filed in resident's medical records. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have potential to be affected. 100% audit for all ordered laboratory tests since 08/01/2016 will be completed by the Director of Nursing and Assistant Director of Nursing on 9/19/2016, 09/20/2016 &	

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F 329	Continued From page 47 milligrams by mouth twice daily for seizures, Seroquel (antipsychotic medication) 25 milligrams by mouth twice daily for psychosis and Pravachol (medication used for hyperlipidemia) 20 milligrams by mouth every evening. A review of physician ' s orders for August 2016 revealed Resident #136 had the following laboratory orders: lipids, HgbA1C and keppra levels q 6 months. A review of the medical record for Resident #136 revealed the last lipid panel was obtained on 10/7/16. There was no record of results for the HgbA1C or the keppra level. On 8/24/16 at 12:30PM, an interview was conducted with the Administrator who stated they were unable to find any laboratory results for the HgbA1C, keppra or lipids. She stated she expected facility staff to follow physician orders and obtain labs as ordered.	F 329	09/21/2016 to identify any other laboratory test ordered but not obtained. Any laboratory test ordered but not obtained will be obtained promptly, and physician will be notified. Findings of this audit will be documented on the “Daily Lab audit form”. 100% audit for all ordered laboratory routine laboratory tests for current residents will be completed by the Director of Nursing and Assistant Director of Nursing on 9/19/2016, 09/20/2016 & 09/21/2016 to identify any other laboratory test ordered but not obtained. Any routine laboratory test ordered but not obtained will be obtained promptly, and physician will be notified. Findings of this audit will be documented on the “Daily Lab audit form”. Measures put in place or systematic changes made to ensure that the deficient practice will not re-occur: Effective 09/19/2016, a new laboratory process implemented in the facility. This process will ensure all ordered laboratory tests are transcribed, obtained, and results reported to resident’s attending physician in a timely manner. This lab process will involve three steps approach to ensure compliance. The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory test to both the facility electronic medical	

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F 329	Continued From page 48	F 329	records and the electronic laboratory system effective 09/19/16. The second step will be completed by a licensed nurse responsible to care for the resident during night (Night shift nurse). Night shift nurse will complete a 24 hours chart check and ensure all orders to include laboratory tests were transcribed appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed. Laboratory tests will be obtained by the licensed laboratory vender on the date ordered to be completed and results will be returned to the facility via facsimile and/or electronically. The third step will involve the nurse on duty on the evening shift, Effective 09/19/2016, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted and communicated to MD in a timely manner. Evening shift nurse will indicate on a daily laboratory log form when the test result are not back during evening shift on that day. Nurse in all shifts are responsible to report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process. The third step will involve the Medical Records clerk or designated staff, will review all laboratory tests the day after labs are ordered to be completed, lerk will also follow up to ensure all completed laboratory test on the prior day were	

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F 329	Continued From page 49	F 329	completed and results obtained. New standing orders lab protocol implemented in the facility effective 09/19/2016. This laboratory protocol will be used to identify type of laboratory tests recommended with different therapeutic medication classes to ensure adequate monitoring. When a resident is admitted, we will initiate a Lab Log Sheet with each month listed. If the resident calls for a standing order lab it will be marked on the appropriate month. At the beginning of each month, the Director of Nursing, Assistant Director of Nursing and/or Nursing manager will review these Lab Log Sheets and entere them into the electronic lab system to be drawn. Revised routine laboratory tests form implemented effectively 09/19/2016. This form will be maintained by the Director of nursing or designated staff who will be responsible to track all standing order laboratory tests in the facility On 09/14/2016, Regional clinical director completed an education to the Director of Nursing, Assistant Director of Nursing and Medical Record Clerk on new laboratory process in the facility. Director of nursing and Assistant Director of Nursing will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new laboratory process. This education will be completed by 09/22/2016. Any licensed nurse not educated by 09/22/2016 will not	

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F 329	Continued From page 50	F 329	be allowed to work until educated. The new laboratory process will be added to new hire orientation process for all licensed nurses effectively 09/22/2016, and will also be provided annually. Monitoring Process: Effective 09/19/2016; Director of Nursing, Assistant Director of Nursing and/or Nursing Manager will review physician orders for the prior day, for proper transcription and follow through. Director of Nursing, Assistant Director of Nursing, Nursing supervisor will follow up to ensure any laboratory tests noted were obtained as ordered. This monitoring will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. The review of the lab order compared to the physician orders will be kept together in the Director of Nursing office as a monitor tool. Effective 09/19/2016; Medical record Clerk will review laboratory log for the prior day(s) and compare with laboratory tests obtained on that date, to ensure all ordered laboratory tests were completed, resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursing and/or the Administrator. This monitoring will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained.	

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F 329	Continued From page 51	F 329	Director of Nursing will report findings to facility Quality Assurance Performance improvement Committee for any additional monitoring needs or alteration of this requirement.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, family and resident interviews, the facility failed to provide sufficient number of direct care nursing staff to meet the needs of residents as evidenced	F 353	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute	9/22/16

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F 353	Continued From page 52 by allowing residents to sit and wait to be fed in the assisted dining room while other residents were being fed, for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed,, failing to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22), not resolving grievances about resident ' s getting help in a timely manner, and failing to shave a male resident while providing activities of daily living care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). The findings included: 1. Cross reference to Tag F 241: Based on record review, observation and interview, the facility allowed residents to sit and wait to be fed in the assisted dining room while other residents were being fed for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed during a lunch meal. 2. Cross reference to Tag F242: Based on staff interview, resident interview and record review the facility failed to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22). 3. Cross reference to Tag F244: Based on record review and staff and resident interview, the facility failed to resolve grievances that were brought in the resident council meetings promptly. 4. Cross reference to Tag F312: Based on staff interview, resident interview, observation and record review the facility failed to shave a male resident while providing activities of daily living care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). 5. On 8/22/16 at 2:30 PM a family member was interviewed (FM #1) who stated that she felt the facility was short staffed and that residents needs for incontinent care and timely feeding of meals	F 353	an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: 1. Cross reference to tag F241: Specified Residents are receiving assistance with meals in a timely manner. 2. Cross reference to tag F242: Specified resident receives ambulation assistance per preference. 3. Cross reference to tag F244: Call bell responses and staffing identified and resolved. 4. Cross reference to tag F312: Specified resident was shaved. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On 08/30/2016, 08/31/2016 and 09/01/2016, Regional Clinical director, Director of Nursing and the Administrator reviewed nursing staffing schedule to identify and to ensure that sufficient numbers of staff were available to provide nursing care to all residents in accordance	

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F 353	Continued From page 53 were not always being met by staff due to not having sufficient staff. On 8/25/16 at 10:17 PM Nursing Assistant #6 was interviewed. She stated that she was a Restorative Aide that had been pulled to work on 200 hall that day so the restorative care she would provide to residents while on restorative would not be provided to those residents since she had been pulled. She indicated that she was solely assigned to 200 hall that day (except Room 215). Review of the facility census revealed there were 17 residents on 200 hall (excluding room 215) as of 8/22/16. She stated also that she was assigned to give 3 showers that day and that she was orienting a new staff member. NA #6 indicated that she felt like she was managing the assignment adequately but that sometimes residents would need to wait while she was carrying out other tasks and that there were days that it felt like they were short staffed. On 8/25/16 at 2:30 PM the Administrator was interviewed. She stated that she had not been working at the facility long but that she was aware the facility had been cited for sufficient staffing on the previous recertification survey. She added that she had incorporated all the citations from the previous recertification in to her Quality Assurance monitoring program upon starting at the facility. The Administrator acknowledged that she had become aware of an incident in February 2016, before she started at the facility, where a Nursing Assistant (NA) had left the facility for a 2 ½ hour period during which her assignment was not formally reassigned to other Nursing Assistants present in the facility. The Administrator stated that she was also aware that the previous citation for sufficient staff had to do with resident ' s not having an assigned NA caregiver and staff not realizing they were	F 353	with residents individual care needs. 1. Cross reference F241; 100% audit of dining room designation. 2. Cross reference F242; 100% choices and preferences audit completed by the Director of Social Services. Current residents on restorative nursing program re-screened by a Licensed Therapist. 3. Cross reference F244; 100% audit of resident council minutes in last 12 months. 4. Cross reference F312; 100% choices and preferences audit completed by the Director of Social Services. 100% grooming audit completed by Restorative aides. Measures put into place or systemic changes made to ensure that the deficient practice will not re-occur: Re-training was completed by the Regional Clinical Director with the Administrator, Director of Nursing and Assistant Director of Nursing regarding scheduling the appropriate number of certified nursing assistants and licensed nurses to allow for provision of nursing care to all residents according to their individual care needs. This in-service took place on 09/19/2016 The nurse on duty is to contact the Director of Nursing and/or on-call administrative nurse in the event staffing needs are not met in their respected assignment, effective 09/19/2016. The Director of Nursing, Assistant	

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F 353	Continued From page 54 responsible for those residents. The Administrator indicated that she was taking steps to ensure this did not reoccur in future. The Administrator also indicated that she was aware of Grievance in regards to timely care, call bells being answered but staff not coming back like they said they would, staff complaining to residents about being short staffed and residents not being assisted to walk daily by restorative like they were supposed to be. In regards to the grievances regarding walking assistance she stated that the records were reviewed and all the residents who had complained had received some walking assistance so the grievance was considered resolved. However she acknowledged that the assistance was not daily as expected by the residents who complained. The Administrator also indicated that she expected residents to receive timely care as needed.	F 353	Director of Nursing and Regional Clinical Director will conduct an education for all staff, all departments, to include full time, part time and as needed staff, in relation to call bell response. Education to include staff responsibilities for answering call lights timely and to not turn off call light until residents needs are met. This education will be completed by 09/22/2016, any staff not educated by 09/22/2016 will not be allowed to work until educated. 1. Cross reference F241; Moving forward, three tables in the main dining room will be designated effective 9/19/2016 for residents who requires assistance with feeding. Nursing assistance will be feeding two residents at a time, effective 9/12/2016. Trays will be delivered to one table at a time effective 9/19/2016. 100% education of proper dining for current nursing staff, to include full-time, part-time and our as needed nursing staff, will be completed by Director of Nursing, Assistant Director of Nursing and/or Nursing supervisor by 9/22/2016. 2. Cross reference F242; Moving forward all current nursing assistants will be responsible to honor resident's choices of walking when requested during their shift and as appropriate, effective 09/19/2016. Resident choices and preferences to include choices for walking will be assessed effective 09/22/2016.	

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100% education of residents rights and to include choices and preferences education involving all staff will be completed by 9/22/16.

3. Cross reference F244;
100% education of all staff will be done by the Director of Social Services, Director of Nursing and Regional Clinical Director on the grievance process from resident council and the buildings process beginning with receiving concerns to following up with a resolution to the appropriate party.

The Director of Nursing, Assistant Director of Nursing and Regional Clinical Director will conduct an education for all staff, all departments, to include full time, part time and as needed staff, in relation to call bell response. Education to include staff responsibilities for answering call lights timely and to not turn off call light until residents needs are met.

4. Cross reference F312;
Moving forward all current nursing assistants will be responsible to honor resident's choices of walking when requested during their shift and as appropriate, effective 09/19/2016.

Resident choices and preferences to include choices for walking will be assessed on admission/readmission, quarterly and with significant changes on “Choices and Preference tool”.

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F 353	Continued From page 56	F 353	100% education of residents rights and to include choices and preferences education involving all staff, was completed. Licensed nurse or certified nursing assistant are expected to identify resident needs for shaving during their shift and offer assistance for shaving as appropriate. Resident grooming status specifically, shaving, is added on the Ambassador rounds worksheet. This will aid identification of shaving needs on a timely manner. 100% residents rights education, to include choices and preferences education of all staff, all departments, to include full time, part time and as needed staff. 100% education for all licensed nursing staff and nursing assistants, to include full time, part time and as needed staff, on ADL care specifically on how to identify resident's preferences for shaving A flexible orientation schedule is available to accommodate timely on-boarding for new employees, to ensure orientation is tailored to individual qualifications of new staff. Monitoring Process Effectively 09/19/2016, Administrator has implemented a QAPI monitoring tool to monitor incoming applications to ensure qualified applicants are processed timely. Director of Nursing or designated	

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administrative staff will interviews all viable applicants within 3 business days of application. Compliance with this requirement will be monitored and documented by the facility Human Resources Director or designee daily (Monday through Friday) for four weeks, weekly x 4 weeks then monthly x 3 months or until a pattern of compliance is maintained.

Effectively 09/19/2016; Director of Nursing, Assistant Director of Nursing and/or nursing supervisor will monitor residents medical acuity and ADL direct care needs daily (Monday through Friday) by reviewing the resident 24 hour report and cross-reference daily staffing schedule to ensure sufficient nursing staff, including certified nursing assistants and licensed nurses, are available daily, to allow for provision of nursing care to all residents according to their individual care needs. The Documentation of this monitoring process will be completed daily (Monday through Friday) x 4 weeks, weekly x 4 weeks then monthly x 3 months or until pattern of compliance is maintained.

Effectively 09/22/2016, one of the following to include by not limited to, Director of Nursing, Assistant Director of Nursing, MDS Nurse # 1, MDS Nurse #2, nursing manager, Certified dietary manager, Activities Director, Medical Records, Director of Social Services, Admissions Coordinator, and/or Business Office Manager will complete walking

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F 353	Continued From page 58	F 353	rounds at least once every shift, to include off shifts and weekends to ensure that nursing staff are responsive to residents needs for assistance. "Walking rounds" monitoring tool will be used to record results of these rounds. Walking rounds will continue every shift x 14 days, then once a day in alternating shifts for 14 more days then, weekly for 4 weeks and then monthly for 3 months or until the pattern of compliance is maintained. Effectively 09/20/2016, the Director of Nursing and Administrator will review current nursing schedule, including certified nursing assistance and licensed nurses, daily (Monday through Friday) at morning team meeting x 4 weeks, then weekly for 4 weeks and then monthly for 3 months, to ensure sufficient nursing staff are available daily, to allow for provision of nursing care for all residents according to their individual care needs. Effectively 09/22/2016 The Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement committee monthly for 3 months or until a trend of compliance is evident. 1. Cross reference F241; An assigned facility administrative staff to include at least one of the following: Administrator, Director of Nursing, Assistant Director of Nursing, RN supervisor, Medical Records Clerk, Activities Director, Certified Dietary Manager will monitor dining rooms at least	

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F 353	Continued From page 59	F 353	one meal daily to include weekends x 4 weeks, then weekly x 4 weeks and then monthly until substantial compliance is maintained for three consecutive months. This monitoring is to ensure residents are fed timely, one table is served at a time and qualified employees will feed two residents at one time. This monitoring will be documented on the 'Dining Monitoring Tool.' Any negative findings identified during the monitoring process will be corrected promptly. The Director of Nursing will report findings of the dining room monitoring process to the Quality Assurance and Performance Improvement Committee monthly for three consecutive months or until a pattern of compliance is achieved. 2. Cross reference F242; Effective on 9/22/16, Activity Director or Administrator will review the completion of "Choices and Preference tool" daily (M-F) for 4 weeks, then weekly for 4 weeks and then monthly until substantial compliance is maintained for three months. Effective on 9/22/16, 'resident appointed ambassador' will monitor daily (Monday through Friday) to ensure residents choices and preference are implemented per "Choices and Preference Tool". A 'resident appointed ambassador' is a department manager who is assigned to a set of residents to monitor and follow up with that resident as a point of contact. They will document their rounds on the 'Ambassador Round Tool.'	

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The Director of Social Services will report audit findings to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved.

3. Cross reference F244

The Administrator, Department Managers, Nursing Supervisor, and/or Manager on Duty will monitor all grievances in relation to call bell responses, staffing or turning off call bell before care is rendered daily (Monday through Friday) for four weeks, weekly for four weeks, then monthly for three months afterwards or until the pattern of compliance is maintained.

The Administrator or Director of Social Services will follow-up with resident council president weekly x4 weeks to ensure grievances have been resolved.

4. Cross reference F312
Resident Appointed Ambassadors (Facility Administrative staff) will complete walking rounds daily (Monday thru Friday) to their assigned residents to ensure appropriate care and services are rendered to include shaving. Although, Ambassador program and rounds will continue to take place as part of the facility Quality Assurance and Performance Improvement program, but the documentation of shaving compliance by resident's assigned ambassador will take place daily (Monday thru Friday) x4 weeks, weekly x4 weeks and then monthly for three months or until the

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F 353	Continued From page 61	F 353	pattern of compliance is maintained. Administrator, Director of Nursing and/or Assistant Director of Nursing will conduct walking rounds to include off shifts and weekends to ensure nursing staff are meeting needs of dependent residents involving shaving. These rounds will be completed once a day for 2 weeks, 3x/week for two more weeks, weekly x4 weeks then monthly x 3 months or until the pattern of compliance is maintained. The Director of Nursing will report findings of walking rounds to Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is obtained.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer ' s instructions and staff interview, the facility failed to discard expired nutritional supplements. The findings included:	F 371	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute	9/22/16

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F 371	Continued From page 62 On 8/22/16 at 1:00PM, an initial tour of the kitchen was conducted with the Dietary manager. A tour of the walk-in cooler revealed a box that contained 35 vanilla Mighty shakes (nutritional supplement) that had been thawed. The box was dated 7/28/16. The instructions on the nutritional supplement stated " Use within 14 days of thawing " . On 8/22/16 at 1:00PM, the Dietary manager stated the nutritional supplements (Mighty shakes) should have been discarded after 14 days per the manufacturer ' s instructions.	F 371	an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective Action will be accomplished for the resident found to have been affected by the deficient practice: On 08/22/2016, certified dietary manager discarded undated, spoiled, and expired items were discarded. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have potential to be affected. On 08/22/2016 Dietary Manager checked walk in refrigerator and all storage areas for undated, expired, and spoiled items. No other items were found to be undated, expired, or spoiled. Measures put in place or systematic changes made to ensure that the deficient practice will not re-occur: On 08/22/2016, the dietary manager completed 100% education with the dietary staff. Education included proper	

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F 371	Continued From page 63	F 371	dating of items, discarding undated, expired, spoiled items, and specific to Mighty Shakes being discarded after 14 days of being thawed from the freezer. To prevent further non-compliance, once items such as Mighty Shakes are pulled from the freezer for use they will be labeled with a thawed date and with a discard date. The dietary staff including cook and aides will be responsible for this process. Monitoring Process: The Dietary Manager and or Administrator will check all nutritional supplements for proper dating of items, expired items, and freshness of items daily x4 weeks, weekly x4 weeks, then monthly until substantial compliance is maintained for two consecutive months. The Dietary Manager will report the summary findings of nutritional shake audits to Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		9/22/16

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F 428	Continued From page 64 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, consultant pharmacist interview and staff interview, the facility pharmacy consultant failed to report and address the need to obtain labs for monitoring medications for one of five residents reviewed for unnecessary medications (Resident #136). The findings included: Resident #136 was admitted to the facility 3/12/15. Cumulative diagnoses included: dementia without behavioral disturbance, hypertension, hyperlipidemia (elevated cholesterol and triglyceride levels) and seizure disorder. A Quarterly Minimum Data Set (MDS) dated 7/21/16 indicated Resident #136 was severely impaired in cognition. Active diagnoses included, in part, hypertension, hyperlipidemia, non-Alzheimer's dementia, psychotic disorder and seizure disorder. A medical record review of physician's orders for August 2016 revealed Resident #136 received the following medications: Keppra (seizure medication) 500 milligrams by mouth twice daily for seizures, Seroquel (antipsychotic medication) 25 milligrams by mouth twice daily for psychosis and Pravachol (medication used for hyperlipidemia) 20 milligrams by mouth every evening.	F 428	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life. Corrective Action will be accomplished for the resident found to have been affected by the deficient practice: Resident #136 laboratory work to include HbA1C (glycosylated hemoglobin), Keppra level and Lipid Panel obtained on 08/24/16 by the contracted licensed laboratory company, result communicated to MD and filed in resident's medical records. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have potential to be affected.	

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F 428	Continued From page 65 A review of physician's orders for August 2016 revealed Resident #136 had the following laboratory orders: lipids, HgbA1C and keppra levels q 6 months. A review of the medical record for Resident #136 revealed the last lipid panel was obtained on 10/7/16. There was no record of results for the HgbA1C or the keppra level. Pharmacist monthly drug regime reviews were reviewed from March through July 2016. The pharmacy consultant did not address the need to obtain laboratory monitoring for lipids, Keppra or HgbA1C as per physic orders. The monthly reviews did state that the last lipid panel was obtained in October 2015. On 8/24/16 at 12:30PM, an interview was conducted with the Administrator who stated they were unable to find any laboratory results for the HgbA1C, keppra or lipids. She stated she expected facility staff to follow physician orders and obtain labs as ordered. On 8/24/16 at 12:35PM, an interview was conducted with the pharmacy consultant who stated Resident #136 was last reviewed on 8/18/16. She stated a problem had been identified during the last month or so that some of the residents had not received their ordered labs. The pharmacy consultant stated a lost had been made of the residents who needed required labs but she could not remember if Resident #136 was on that list. She stated she had been focused on the psychotropic medications and the gradual dose reduction (GDR) for his antidepressant. She stated she must have missed the fact that	F 428	100% audit for all ordered laboratory tests since 08/01/2016 will be completed by the Director of Nursing and Assistant Director of Nursing on 9/19/2016, 09/20/2016 & 09/21/2016 to identify any other laboratory test ordered but not obtained. Any laboratory test ordered but not obtained will be obtained promptly, and physician will be notified. Findings of this audit will be documented on the “Daily Lab audit form”. 100% audit for all ordered laboratory routine laboratory tests for current residents will be completed by the Director of Nursing and Assistant Director of Nursing on 9/19/2016, 09/20/2016 & 09/21/2016 to identify any other laboratory test ordered but not obtained. Any routine laboratory test ordered but not obtained will be obtained promptly, and physician will be notified. Findings of this audit will be documented on the “Daily Lab audit form”. Measures put in place or systematic changes made to ensure that the deficient practice will not re-occur: Effective 09/19/2016, a new laboratory process implemented in the facility. This process will ensure all ordered laboratory tests are transcribed, obtained, and results reported to resident’s attending physician in a timely manner. This lab process will involve three steps approach to ensure compliance.	

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F 428	Continued From page 66 the Keppra, HgbA1C and lipids had not been obtained as ordered by the physician and should have asked for the labs to be drawn. On 8/25/16 at 3:15PM, an interview was conducted with the Administrator who stated she expected the pharmacy consultant to monitor and report if any labs were needed for residents.	F 428	The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory test to both the facility electronic medical records and the electronic laboratory system effective 09/19/16. The second step will be completed by a licensed nurse responsible to care for the resident during night (Night shift nurse). Night shift nurse will complete a 24 hours chart check and ensure all orders to include laboratory tests were transcribed appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed. Laboratory tests will be obtained by the licensed laboratory vender on the date ordered to be completed and results will be returned to the facility via facsimile and/or electronically. The third step will involve the nurse on duty on the evening shift, Effective 09/19/2016, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted and communicated to MD in a timely manner. Evening shift nurse will indicate on a daily laboratory log form when the test result are not back during evening shift on that day. Nurse in all shifts are responsible to report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process. The third step will involve the Medical	

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F 428	Continued From page 67	F 428	Records clerk will review all laboratory tests the day after labs are ordered to be completed, medical records clerk will also follow up to ensure all completed laboratory test on the prior day were completed and results obtained. New standing orders lab protocol implemented in the facility effective 09/19/2016. This laboratory protocol will be used to identify type of laboratory tests recommended with different therapeutic medication classes to ensure adequate monitoring. Revised routine laboratory tests form implemented effectively 09/19/2016. This form will be maintained by the Director of nursing, Assistant Director of Nursing and/or RN Supervisor who will be responsible to track all standing order laboratory tests in the facility On 09/14/2016, Regional clinical director completed an education to the Director of Nursing, Assistant Director of Nursing and Medical Record Clerk on new laboratory process in the facility. Licensed pharmacist re-educated on 09/20/2016 by the pharmacy clinical Director on her duties and responsibilities to report and address the need to obtain labs for monitoring medications. On 09/20/2016 Pharmacy Director of Clinical Services will re-educate, facility licensed pharmacist on her duties and responsibilities to report and address the need to obtain labs for monitoring	

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medications.

Director of nursing and/or Assistant Director of nursing will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new laboratory process. This education will be completed by 09/22/2016. Any licensed nurse not educated by 09/22/2016 will not be allowed to work until educated.

The new laboratory process will be added to new hire orientation process for all licensed nurses effectively 09/22/2016, and will also be provided annually.

Monitoring Process:
Effective 09/19/2016; Director of Nursing, Assistant Director of Nursing or RN Supervisor will review physician orders for the prior day, for proper transcription and follow through. Nursing administrative staff will follow up to ensure any laboratory tests noted is obtained as ordered. This monitoring will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained.

Effective 09/19/2016; Medical record Clerk will review laboratory log for the prior day(s) and compare with laboratory tests obtained on that date, to ensure all ordered laboratory tests were completed, resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursing and/or the Administrator. This monitoring

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F 428	Continued From page 69	F 428	will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. Effective 09/22/2016; Licensed Pharmacy will monitor completion of laboratory tests needed for monitoring medication monthly. Reports of past due and due laboratory tests will be generated and reported to the Director of Nursing monthly and addressed promptly. Effectively 09/22/2016; Director of Nursing will report findings of lab audit and monitoring process to the QAPI committee monthly x 3 months or until the pattern of compliance is maintained.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		9/22/16

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F 431	Continued From page 70 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to discard expired medications in 1 (400/500 medication room) of 2 medication rooms and to date a medication in 1 (400 medication cart) of 4 medication carts. The findings included: 1. On 8/24/16 at 5:10 PM, the medication room on the 400/500 hall was observed. In the refrigerator, there were 2 opened bottles of Tuberculin Purified Protein Derivatives (PPD), used to diagnose Tuberculosis infection, observed. One opened bottle of PPD had an open date of 7/1/16 and the other opened bottle of PPD had an open date of 7/10/16. The manufacturer's specification for Tuberculin PPD indicated to discard 30 days after opening.	F 431	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: No Residents were named	

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F 431	Continued From page 71 On 8/24/16 at 5:12 PM, Nurse #2 was interviewed. Nurse #2 stated that it was her responsibility to check the medication room including the refrigerator for expired medications. She added that she was told that the medication room had already been checked so she did not check it. On 8/25/16 at 9:30 AM, the Nurse Consultant was interviewed. The Nurse Consultant indicated that PPD should be discarded 30 days after opening per the manufacturer's recommendation. He added that the unit manager (Nurse #2) was responsible in checking the medication room and medication carts for expired and undated medications. 2. On 8/24/16 at 5:10 PM, the medication room on 400/500 hall was observed. There was a bottle of Diltiazem ER (anti -hypertensive drug) 240 milligrams (mgs) with an expiration date of 10/16/15, a bottle of Duloxetine (anti-depressant drug) 60 mgs with an expiration date of 7/19/15 and a bottle of Lansoprazole (used to treat stomach ulcers) 30 mgs with an expiration date of 6/28/16. On 8/24/16 at 5:12 PM, Nurse #2 was interviewed. The nurse stated that it was her responsibility to check the medication room for expired medications. She added that she was told that the medication room had already been checked so she did not check it. On 8/25/16 at 9:30 AM, the Nurse Consultant was interviewed. The Nurse Consultant indicated that the unit manager (Nurse #2) was responsible in	F 431	1. The opened bottles of Tuberculin Purified Protein Derivatives from the 400/500 hall were discarded on 8/24/16. 2. The bottle of Diltiazem Extended Release and the bottle of Duloxetine from the 400/500 hall were discarded on 8/24/16. 3. The opened foil of Budesonide inhalation from the 400 hall medication cart was discarded on 8/24/16. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. On 09/16/16, the Director of Nursing, Assistant Director of Nursing, Nurse supervisor checked all medication storage rooms and medication carts to ensure expired medications had been removed and that all opened Budesonide inhalation were labeled with an opened date. Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur: Moving forward, effective 09/20/2016, an incoming nurse will review the medication cart to ensure all open inhalers are dated when opened. Findings will be recorded on “short term medication expiration audit tool”. This tool will be maintained in Narcotic count book.	

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F 431	Continued From page 72 checking the medication room and medication carts for expired and undated medications. 3. On 8/24/16 at 5:15 PM, the 400 hall medication cart was observed. There was an opened foil of Budesonide inhalation (used to prevent symptoms of asthma) observed with 4 vials inside the foil. The opened foil had no date of opening. The manufacturer's instruction on the box read " once the foil/envelop is opened, use the vial/ampule within 2 weeks. " On 8/24/16 at 5:20 PM, Nurse #3 was interviewed. The nurse stated that the foil of Budesonide should be dated when opened. Nurse # 3 confirmed that the foil was undated. On 8/24/16 at 5:12 PM, Nurse #2 was interviewed. The nurse stated that it was her responsibility to check the medication carts for expired and undated medications. She added that it was her fault for not checking the medication carts. On 8/25/16 at 9:30 AM, the Nurse Consultant was interviewed. The Nurse Consultant indicated that the unit manager (Nurse #2) was responsible in checking the medication room and medication carts for expired/undated medications.	F 431	100% education started with Licensed Nurses on 09/17/16 and to be completed by 9/22/2016. Education included review of expiration dates prior to administration of medications, and proper dating of inhalants when opened. Any licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. This education will be updated and added to the new hire orientation packet. The Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will be responsible for checking medication carts and medication rooms weekly. Monitoring Process: Director of Nursing, Assistant Director of Nursing and/or Nursing Supervisor will monitor the completion of “short term medication expiration tool” daily (Monday through Friday) x 4 weeks, weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained, to ensure that open nurses on duty comply with checking medication carts at the beginning of their shift and ensuring open inhalants are dated, when opened, and that all expired medications are discarded appropriately. Director of Nursing, Assistant Director of Nursing and/or Nursing Supervisor will check medication carts and medication rooms, daily (Monday through Friday) x 4	

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F 431	Continued From page 73	F 431	weeks, weekly x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained, to ensure that open Inhalants are dated, when opened, and that all expired medications are discarded appropriately. The Director of Nursing will report findings of the medication checks to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		9/22/16

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F 520	Continued From page 74 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff, resident and family interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 9/25/14 and 9/17/15 recertification surveys. This was for the recited deficiencies in the areas of Dignity (F241), and Activities of Daily Living (F312) cited 9/25/14 and 9/17/15 and in the areas of Assessment Accuracy (F278), Comprehensive Care Plans (F280), Sufficient Staffing (F353) and Sanitary Conditions (F371) cited 9/17/15. These deficiencies were cited again on the recertification survey of 8/25/16. The continued failure of the facility during three consecutive federal surveys of record (F241, F312) and two consecutive federal surveys of record (F278, F280, F353 and F371) shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: F241 Dignity: Based on record review, observation and interview, the facility allowed residents to sit and wait to be fed in the assisted dining room while other residents were being fed for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed during a lunch meal. During the 9/25/14 recertification survey the facility had a F241 citation for failing to keep a urinary catheter bag covered and for failing to	F 520	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: 1. Cross reference to tag F241: Resident #26 is receiving assistance with meals in a timely manner. • Resident #94 no longer in the facility. • Resident #81 no longer in the facility. 2. Cross reference F278 • Resident # 1 1a. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on 08/24/2016 to indicate in Question J1400 that resident had life expectancy of 6 months. 1b. Minimum Data Set dated 7/29/16 was modified by MDS Nurse #1 on 08/24/2016	

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F 520	Continued From page 75 dress a resident in their own clothes appropriate for the time of day. During the 9/17/15 recertification survey the facility had a F241 citation for failing to provide incontinent care timely and for failing to knock before entering a resident ' s room. F278 Assessment Accuracy: Based on resident interview, staff interview, observation, and medical record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of life expectancy (Resident #1), hospice care (Resident #1), respite care (Resident #1), active diagnoses (Residents #1 and #11), medications (Residents #11 and #72), behaviors (Resident #103), dental status (Resident #1), and preferences for customary and routine activities (Resident #96) for 5 of 26 sampled residents. During the 9/17/15 recertification survey the facility had a F278 citation for failing to accurately code the Minimum Data Set for Level II Preadmission Screening and Resident Review and for Pressure Ulcers. F280 Comprehensive Care Plans: Based on observation, staff interview, and medical record review the facility failed to review and revise plans of care in the areas of intravenous (IV) fluids (Resident #147) and nutrition (Resident #72) for 2 of 26 sampled residents. During the 9/17/15 recertification survey the facility had a F280 citation for failing to review and revise care plans for activities of daily living and medications. F312 Activities of Daily Living Care: Based on staff interview, resident interview, observation and record review the facility failed to shave a male resident while providing activities of daily living	F 520	to indicate in Question O0100 K 1 and 2 modified to indicate resident was receiving Hospice services while not a resident and while a resident. 1c. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on 08/24/2016 to indicate in Question O0100L modified to indicate resident was admitted for respite services while a resident. 1d. Minimum data Set dated 7/29/16 was modified/corrected by MDS Nurse #1 on 08/24/2016 to indicate in Section I, to include anxiety as an active diagnosis. 1e. Minimum Data Set dated 7/29/16 was modified/corrected by MDS Nurse # 1 on 08/24/2016 to indicate in Question L0200, that resident had no natural teeth. • Resident #11 2a. Minimum Data Set dated 7/13/16 was modified/corrected by MDS Nurse #1 on 09/17/2016 to indicate in question N0410, the correct number of days of use of antipsychotic medications in 7 day look back period. 2b. Minimum Data Set dated 7/13/16 was modified/corrected by MDS Nurse #1 on 09/17/2016 to indicate in Section I , the correct active diagnosis. • Resident #96 is no longer at the facility. • Resident #72 4a. Minimum Data Set dated 7/25/16 was modified/corrected by MDS Nurse #1 on 09/17/2016 to indicate in question N0410, the correct number of days of antibiotic received. • Resident #103 is no longer at the facility.	

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F 520	Continued From page 76 care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). During the 9/25/14 recertification survey the facility had a F312 citation for failing to provide proper incontinent and nail care. During the 9/17/15 recertification survey the facility had a F312 citation for failing to provide incontinent care to a resident who needed incontinent care and for failing to shave a resident. F353 Sufficient Staff: Based on record review, observation and staff, family and resident interviews, the facility failed to provide sufficient number of direct care nursing staff to meet the needs of residents as evidenced by allowing residents to sit and wait to be fed in the assisted dining room while other residents were being fed, for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed,, failing to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22), not resolving grievances about resident ' s getting help in a timely manner, and failing to shave a male resident while providing activities of daily living care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). During the 9/17/15 recertification survey the facility had a citation for failing to have an assigned Nursing Assistant for 7 of 57 residents, for failing to provide timely incontinent care and for failing to have sufficient staff to maintain the dignity of a resident requiring incontinent care. F371 Sanitary Conditions: Based on observation, manufacturer ' s instructions and staff interview, the facility failed to discard expired nutritional supplements. During the 9/17/15 recertification survey the facility had a F371 citation for failing to discard	F 520	3. Cross reference to tag F280 • Resident #147 care plan for intravenous (IV) fluid discontinued by the MDS coordinator on 8/25/2016. Resident #72 nutrition care plan reviewed and revised and "no straw" removed from care plan on 08/25/2016. 4. Cross reference to tag F312 • Resident #22 was shaved on 09/19/2016 by assigned nursing assistant. 5. Cross reference to tag 353: • Cross reference to tag F241: Specified Residents are receiving assistance with meals in a timely manner. • Cross reference to tag F242: Specified resident receives ambulation assistance per preference. • Cross reference to tag F244: Call bell responses and staffing identified and resolved. • Cross reference to tag F312: Specified resident was shaved. 6. Cross reference to tag F371 • On 08/22/2016, Certified dietary manager discarded undated, spoiled, and expired items were discarded Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: All residents have the potential to be affected. 1.Cross Reference F241: 100% audit of all active residents completed on 9/15/2016 by Dietary Manager to determine the assistance required during meals and dining room	

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F 520	Continued From page 77 rotten food, failing to date food when thawed and for failing to completely cover hair with a hair net during the tray line. An interview was conducted with the Administrator on 8/25/16 at 3:30 PM. She stated that she had only recently started as the Administrator at the facility but that she had already reviewed the citations from 9/17/15 and incorporated monitoring in those areas within the Quality Assurance (QA) Program. She indicated that the 8/25/16 deficiencies for these citations primarily related to a different aspect of each F tag than was cited during previous surveys and that expanding the focus of their QA monitoring in those newly identified areas would resolve the repeated deficiencies. However she also indicated that as a new Administrator in the facility she was still working on resolving a few past issues that may not have been addressed by previous QA efforts before she started at the facility.	F 520	designation for all three meals. Findings documented on "Dining Designation Audit" tool. 2. Cross Reference F 278: 100% of current residents will be audited by Director of Social Services to determine if they are receiving Hospice Services and Respite Services. The results of the audit indicated that no other residents were hospice or respite services. 1a. 100% of residents on hospice services were audited by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 for accuracy on Question J1400,Prognosis. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. The results of the audit indicated that all residents currently on hospice were coded correctly under Question J1400. 1b. 100% of residents on hospice services were audited by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 for accuracy in Question O0100K, Hospice Care while not a resident and while a resident. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. The results of the audit indicated that all residents currently on hospice were coded correctly under Question O0100K. 1c. 100% audit of residents on respite care were conducted by MDS Nurse #1 and #2 on 09/16/16, 09/17/16, and	

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F 520	Continued From page 78	F 520	09/18/16 to ensure that all residents admitted for respite care were coded accurately in Question O0100L, Respite Care. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. At the time of audit no residents were currently on respite care. 1d. 100% audit of all active resident's most recent MDS assessment was conducted by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 to ensure all active diagnoses were coded appropriately in section I, Oral/Dental status in question L0200 and number of days resident received antipsychotic medication and antibiotic therapy in the seven day look back period on question N0410A and N0410F consecutively per RAI guideline. The audit will also include rejection of care coding in question E0800 as per RAI guideline. Modifications/corrections done to Minimum Data Set as indicated per RAI guidelines. The active diagnosis audit for Section I revealed 9 other assessments were coded incorrectly. The audit of Question L0200 revealed no other coding errors. The antipsychotic medication audit revealed 4 other assessments were coded incorrectly. The antibiotic audit revealed 1 other assessments was coded incorrectly. The rejection of care audit revealed no other residents were coded incorrectly. 3. Cross Reference F280:	

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F 520	Continued From page 79	F 520	100% of audit for current residents completed on 09/16/2016, 09/17/16, and 9/18/2016, by the Director of Nursing, Assistant Director of Nursing, MDS nurse #1 and MDS nurse #2 to identify any other residents who have had an order for intravenous fluid in the last 12 months, to ensure their care plan is revised as appropriately. The audit revealed that 2 other residents had IV fluids ordered in the last twelve months but did not have a care plan for the IV fluids. 100% audit of current residents completed on 09/16/2016, 09/17/16 and 9/18/2016, by the Director of Nursing, Assistant Director of Nursing, MDS nurse #1 and MDS nurse #2 to identify any other residents with adaptive eating devices, and/or any restrictions of not using straw The audit revealed 11 other residents had adaptive eating devices that were not updated on their care plan. 4. Cross Reference F312: 100% choices and preferences audit completed by the Director of Social Services and the Administrator on 09/15/2016 & 09/16/2016 to determine each residents choices and preferences, to include shaving relation to walking. Findings of this audit is documented on the "Resident Choices Audit tool". At the time of the audit, all shaving was current.	

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100% grooming audit completed by Restorative aides to identify any other resident who may be require shaving. This audit was completed on 09/16/16, 09/17/16 and 09/18/16. Any findings will be addressed promptly.

5. Cross Reference F353:
On 08/30/2016, 08/31/2016 and 09/01/2016, Regional Clinical director, Director of Nursing and the Administrator reviewed nursing staffing schedule to identify and to ensure that sufficient numbers of staff were available to provide nursing care to all residents in accordance with residents individual care needs.
Cross reference F241; 100% audit of dining room designation.
Cross reference F242; 100% choices and preferences audit completed by the Director of Social Services. Current residents on restorative nursing program re-screened by a Licensed Therapist.
Cross reference F244; 100% audit of resident council minutes in last 12 months.

Cross reference F312; 100% choices and preferences audit completed by the Director of Social Services. 100% grooming audit completed by Restorative aides.

6. Cross Reference F371:
On 08/22/2016 Dietary Manager checked walk in refrigerator and all storage areas for undated, expired, and spoiled items. No other items were found to be undated,

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F 520	Continued From page 81	F 520	expired, or spoiled. Measures put into place or systemic changes made to ensure that the deficient practice will not re-occur: On 9/19/2016, Regional Clinical Director will complete re-training with facility Administrator and The Director of Nursing, regarding Quality Assurance, Performance Improvement Program (QAPI) process. This education included how to identify quality deficiencies specifically on skin care and wound management program as well as ways to establish system that will ensure consistent, measurable outcomes. The education will also cover methods on how to track and trend data, as well as best practices on root cause analysis. The administrator and the Director of Nursing will then re-train QAPI committee members on how to properly complete the Quality Assurance and Performance Improvement Plan to assure and ensure the facility sustain an effective Quality Assurance and Performance Improvement plan to prevent repeat non-compliance with Federal and/or State Regulations. 1. Cross reference F241; Moving forward, three tables in the main dining room will be designated effective 9/19/2016 for residents who requires assistance with feeding. Nursing assistance will be feeding two residents at a time, effective 9/12/2016. Trays will be delivered to one table at a time effective 9/19/2016.	

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F 520	Continued From page 82	F 520	100% education of all current nursing staff, to include full-time, part-time and our as needed nursing staff, will be completed by Director of Nursing, Assistant Director of Nursing and/or Nursing supervisor by 9/22/2016. This education will cover facility new dining practices to include; assisting residents on one table at a time, feeding two residents on the same table at one time and ensure all residents are fed in a timely manner. Any nursing staff not educated by 9/22/2016 will not be allowed to work until educated. This education will taught annually and added to the new hire orientation packet. 2. Cross reference F278: Effectively 09/19/2016 The Admission Director or Business Office Manager will complete pre-admission screening for all residents admitted to the facility and followed by the Program of All- Inclusive Care for the Elderly (PACE). The screening will identify program and services received by the resident before admission in the community, that will continue to be rendered at the facility to include but not limited to Hospice care. The Admission Director or Business Office Manager will receive such information by contacting the referring agent via phone, fax or E-mail, and document her findings on the “Admission/Readmission communication form” Effective 09/19/2016, the admitting nurse will write a Hospice Care order for any new admit/readmit indicated on the “Admission/Readmission communication	

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F 520	Continued From page 83	F 520	form" to have Hospice care, and interim care plan for Hospice will be generated. Effective 09/19/16, Director of Nursing, Assistant Director of Nursing and/or MDS nurse will review physician orders at the Monday thru Friday clinical meeting for the need to update or initiate care plans. Upon findings, appropriate care plans will be updated and or initiated, especially for orders involving Hospice Services. Any identified Hospice order will be documented on "Daily Priority List form" with findings and action taken. On 09/16/2016; Regional Clinical Director re-educated MDS nurse #1, MDS nurse #2, Director of Social Services, Activities Director, Director of Nursing and Assistant Director of nursing and Certified Dietary manager on how to, and when to, develop a care plan for any resident in the facility. Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will complete 100% education on the revised facility care plan development process for all licensed nurses. This education will be completed by 09/22/2016. Any Licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. Education on the facility care plan development process is added on new hires orientation education for all new licensed nurses. This education will also be provided annually for all Licensed nurses. 3. Cross Reference of F280:	

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F 520	Continued From page 84	F 520	The Regional Clinical Director re-educated MDS nurses (#1 & #2), Social Services Director, and nursing administrative staff on how to review, revise and update Care Plan in a timely manner. This re-education was conducted on 9/19/2016. Moving forward licensed nurses are also expected to update care plans with new approaches as changes arise, effective 09/20/2016. Director of Nursing, Assistant Director of Nursing or RN Supervisor will complete 100% education on the revised facility care plan updating process for all licensed nurses will be completed by 09/22/2016. Any Licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. Education on the facility care plan updating process is added to the new hires orientation education for all new licensed nurses. This education will also be provided annually for all Licensed nurses. 4. Cross reference F312; Moving forward all current nursing assistants will be responsible to honor resident's choices of walking when requested during their shift and as appropriate, effective 09/19/2016. Resident choices and preferences to include choices for walking will be assessed on admission/readmission, quarterly and with significant changes on “Choices and Preference tool”.	

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100% education of residents rights and to include choices and preferences education involving all staff, was completed.
Licensed nurse or certified nursing assistant are expected to identify resident needs for shaving during their shift and offer assistance for shaving as appropriate.
Resident grooming status specifically, shaving, is added on the Ambassador rounds worksheet. This will aid identification of shaving needs on a timely manner.

100% residents rights education, to include choices and preferences education of all staff, all departments, to include full time, part time and as needed staff.

100% education for all licensed nursing staff and nursing assistants, to include full time, part time and as needed staff, on ADL care specifically on how to identify resident's preferences for shaving

A flexible orientation schedule is available to accommodate timely on-boarding for new employees, to ensure orientation is tailored to individual qualifications of new staff.

5. Cross reference F353
On 08/30/2016, 08/31/2016 and 09/01/2016, Regional Clinical director, Director of Nursing and the Administrator reviewed nursing staffing schedule to

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F 520	Continued From page 86	F 520	identify and to ensure that sufficient numbers of staff were available to provide nursing care to all residents in accordance with residents individual care needs. Cross reference F241; 100% audit of dining room designation. Cross reference F242; 100% choices and preferences audit completed by the Director of Social Services. Current residents on restorative nursing program re-screened by a Licensed Therapist. Cross reference F244; 100% audit of resident council minutes in last 12 months. Cross reference F312; 100% choices and preferences audit completed by the Director of Social Services. 100% grooming audit completed by Restorative aides. 6. Cross reference F371 On 08/22/2016 Dietary Manager checked walk in refrigerator and all storage areas for undated, expired, and spoiled items. No other items were found to be undated, expired, or spoiled. Monitoring Process Effectively 09/21/2016; the facility administrator or designated staff will monitor all deficiencies cited in the last three and track progress to ensure the facility sustain an effective quality assurance program to ensure no repeat deficiencies are cited in the future. This	

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F 520	Continued From page 87	F 520	monitoring will be done monthly x 12 months. 1.Cross reference F241 An assigned facility administrative staff to include at least one of the following: Administrator, Director of Nursing, Assistant Director of Nursing, RN supervisor, Medical Records Clerk, Activities Director, Certified Dietary Manager will monitor dining rooms at least one meal daily to include weekends x 4 weeks, then weekly x 4 weeks and then monthly until substantial compliance is maintained for three consecutive months. This monitoring is to ensure residents are fed timely, one table is served at a time and qualified employees will feed two residents at one time. This monitoring will be documented on the 'Dining Monitoring Tool.' Any negative findings identified during the monitoring process will be corrected promptly. The Director of Nursing will report findings of the dining room monitoring process to the Quality Assurance and Performance Improvement Committee monthly for three consecutive months or until a pattern of compliance is achieved. 2. Cross reference F278 Effective 09/19/2016, prior to submission, Director of Social Services and/or Activities Director will review completed MDS Assessment by MDS Nurse #1 or MDS Nurse #2 to ensure Question J1400, Question O0100K, Question O0100L, Section I, Question LO200, Question	

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F 520	Continued From page 88	F 520	N0410, and Question E0800 are coded accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. Effective 09/19/2016, prior to submission, MDS Nurse #1 and/or MDS Nurse #2 (Whomever is not signing off on the assessment) will review completed MDS assessment to ensure question E0800 is coded accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments monthly for 3 months or until compliance is achieved. MDS nurse #1, MDS nurse #2, Director of Social Services, and.or Activities Director will present the findings of this audit, effective 9/22/2016, to the Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is achieved. 3. Cross reference F280 Director of Nursing, Assistant Director of nursing, Nursing Supervisor as well as MDS nurse (#1 & #2), will monitor compliance of care plan update by conducting clinical meeting daily	

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F 520	Continued From page 89	F 520	(Monday-Friday), effective 9/20/2016, this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure care plans are developed and updated timely. Findings from this meeting will be documented on a daily priority list form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are completed. Director of nursing will review the completion of priority list weekly x 4 weeks, then monthly x 3 months. Director of Nursing will report findings to facility Quality Assurance Performance improvement Committee for any additional monitoring needs or alteration of this requirement. 4. Cross Reference F312 Resident Appointed Ambassadors (Facility Administrative staff) will complete walking rounds daily (Monday thru Friday) to their assigned residents to ensure appropriate care and services are rendered to include shaving. Although, Ambassador program and rounds will continue to take place as part of the facility Quality Assurance and Performance Improvement program, but the documentation of shaving compliance by resident's assigned ambassador will take place daily (Monday thru Friday) x4	

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weeks, weekly x4 weeks and then monthly for three months or until the pattern of compliance is maintained.

Administrator, Director of Nursing and/or Assistant Director of Nursing will conduct walking rounds to include off shifts and weekends to ensure nursing staff are meeting needs of dependent residents involving shaving. These rounds will be completed once a day for 2 weeks, 3x/week for two more weeks, weekly x4 weeks then monthly x 3 months or until the pattern of compliance is maintained.

The Director of Nursing will report findings of walking rounds to Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is obtained.

5. Cross reference F353
Effectively 09/19/2016, Administrator has implemented a QAPI monitoring tool to monitor incoming applications to ensure qualified applicants are processed timely. Director of Nursing or designated administrative staff will interviews all viable applicants within 3 business days of application. Compliance with this requirement will be monitored and documented by the facility Human Resources Director or designee daily (Monday through Friday) for four weeks, weekly x 4 weeks then monthly x 3 months or until a pattern of compliance is maintained.
Effectively 09/19/2016; Director of Nursing and/or Administrative Nurses will monitor

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F 520	Continued From page 91	F 520	residents medical acuity and ADL direct care needs daily (Monday through Friday) by reviewing the resident 24 hour report and cross-reference daily staffing schedule to ensure sufficient nursing staff, including certified nursing assistants and licensed nurses, are available daily, to allow for provision of nursing care to all residents according to their individual care needs. The Documentation of this monitoring process will be completed daily (Monday through Friday) x 4 weeks, weekly x 4 weeks then monthly x 3 months or until pattern of compliance is maintained. Effectively 09/22/2016, one of the following to include by not limited to, Director of Nursing, Assistant Director of Nursing, MDS Nurse # 1, MDS Nurse #2, nursing manager, Certified dietary manager, Activities Director, Medical Records, Director of Social Services, Admissions Coordinator, and/or Business Office Manager will complete walking rounds at least once every shift, to include off shifts and weekends to ensure that nursing staff are responsive to residents needs for assistance. “Walking rounds” monitoring tool will be used to record results of these rounds. Walking rounds will continue every shift x 14 days, then once a day in alternating shifts for 14 more days then, weekly for 4 weeks and then monthly for 3 months or until the pattern of compliance is maintained. Effectively 09/20/2016, the Director of Nursing and Administrator will review current nursing schedule, including certified nursing assistance and licensed	

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F 520	Continued From page 92	F 520	nurses, daily (Monday through Friday) at morning team meeting x 4 weeks, then weekly for 4 weeks and then monthly for 3 months, to ensure sufficient nursing staff are available daily, to allow for provision of nursing care for all residents according to their individual care needs. Effectively 09/22/2016 The Director of Nursing will compile a summary report of all monitoring efforts and present to the facility Quality Assurance and Performance Improvement committee monthly for 3 months or until a trend of compliance is evident. 6. Cross Reference F371 The Dietary Manager and or Administrator will check all nutritional supplements for proper dating of items, expired items, and freshness of items daily x4 weeks, weekly x4 weeks, then monthly until substantial compliance is maintained for two consecutive months. The Dietary Manager will report the summary findings of nutritional shake audits to Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved.	